The availability of section 12 doctors for Mental Health Act assessments: interview perceptions and analysis of the national MHA Approvals Register Database

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Contents
Summary ......................................................................................................................... i
Chapter 1 Introduction ................................................................................................. 1
  1.1. Background ........................................................................................................... 1
  1.2. Research aim and questions .............................................................................. 2
  1.3. Structure of the report ....................................................................................... 2
Chapter 2 Methods ......................................................................................................... 4
  2.1. Introduction ......................................................................................................... 4
  2.2. Interviews ............................................................................................................ 4
  2.3. Qualitative data analysis .................................................................................... 7
  2.4. Research ethics .................................................................................................. 7
  2.5. Patient and Public Involvement and Engagement (PPIE) .............................. 7
  2.6. Analysis of the Approvals Register ................................................................. 7
Findings ......................................................................................................................... 10
Chapter 3 Analysis of the Approvals Register .......................................................... 11
  3.1. Introduction ....................................................................................................... 11
  3.2. Overall numbers ............................................................................................... 11
  3.3. Grades of s12 doctors ....................................................................................... 11
  3.4. Speciality of s12 doctors .................................................................................. 12
  3.5. Availability for MHA assessments ................................................................... 13
  3.6. Availability by sub-specialism ......................................................................... 16
  3.7. Rurality ............................................................................................................... 17
Chapter 4 Motivations and training ........................................................................... 19
  4.1. Introduction ....................................................................................................... 19
  4.2. Reasons for becoming s12 approved ............................................................... 19
  4.3. Reasons for continuing working as a s12 approved doctor? ......................... 20
  4.4. Reasons to consider giving up s12 status or stop doing MHA assessments on a fee-paying basis ............................................. 21
  4.5. Training ............................................................................................................. 23
Chapter 5 Organisational contexts and s12 doctors’ experiences ............................ 27
  5.1. Introduction ....................................................................................................... 27
  5.2. Organisational responsibility ......................................................................... 27
  5.3. Working as a s12 doctor .................................................................................. 30
Chapter 6 Arranging MHA assessments .................................................................... 37
  6.1. Introduction ....................................................................................................... 37
  6.2. Ways of arranging MHA assessments ............................................................... 37
  6.3. Involvement of doctors who have previous acquaintance of the person ....... 40
  6.4. Arranging MHA assessments without previous acquaintance ....................... 42
Summary

Introduction and methods

This report presents the findings of a study which explored the reasons for and nature of reported difficulties in accessing section 12 (s12) doctors for Mental Health Act (MHA) assessments. For a person to be legally detained in hospital, the law requires that MHA assessments must involve such doctors and also other professionals (mainly social workers) acting as Approved Mental Health Professionals (AMHPs). The study was commissioned by the Department of Health and Social Care (DHSC). We combined interviews (n=52) with an analysis of the national MHA Approvals Register Database (Approvals Register), maintained on behalf of the Secretary of State for Health and Social Care by four regional Approvals Panels. This is the first time that external analysts have been given this access and we are grateful for this permission. We also consulted with people with direct experience of being assessed by s12 doctors for their views on our initial findings.

Numbers and availability of s12 doctors

In February 2021, there were 9,907 s12 doctors on the Approvals Register. Over 90% are either consultant psychiatrists or Specialist Trainee (ST) psychiatrists, only 2% are GPs and 79 (<1%) are recorded as ‘independent s12 doctors’, who are not employed by the NHS in any form. Just over a third (n=3,478, 36%) of s12 doctors had declared they would be available for fee-paying MHA assessments: their availability is highest in early evenings (from 17:00 to 21:00) and lowest between midnight and 09:00. There are higher concentrations of s12 doctors per 100,000 of the population in major urban centres and in more deprived areas.

Motivations and discouraging factors

Becoming s12 approved was seen as essential to the career of hospital psychiatrists and viewed as a valuable part of the role. However, for GPs, becoming s12 approved is very much optional and there seems to be no career advantage. Undertaking MHA assessments was valued as a way of maintaining clinical experience for retired doctors, or those taking time out of practice to study. A small number of hospital psychiatrists and retired doctors were at least in part motivated by the potential earnings from fees. Some s12 doctors did not want to be contacted about MHA assessments during the evenings or overnight. Others were put off by difficulties in securing payment, which was a very common complaint. A small number of retired doctors found that getting revalidated as a doctor was difficult, making it difficult to continue as s12 doctors.

Training

Most practising psychiatrists felt that the two days of non-assessed s12 training was sufficient because it was building on their basic and advanced psychiatric training and clinical work. They also thought that doctors completing the training did not need to be assessed before being approved. However, some AMHPs and other Key Informants we interviewed did feel that assessment would be a good indication of competence of s12 doctors. Some also suggested that GPs and other non-psychiatrist s12 doctors may need extra training and observed assessments. Further training on the practicalities of MHA assessments, cultural awareness and case discussions were all felt to be potentially valuable.

Organisational context

How responsibility for paying s12 doctors’ fees is divided between Clinical Commissioning Groups (CCGs) and NHS Trusts was considered to partly explain the complexity of payment arrangements for s12 doctors’ fees. This split was also felt to influence the priority given to the choice by AMHPs of Trust-based or independent s12 doctors for MHA assessment work.
**Working as a s12 doctor**
Most s12 doctors appeared quite happy with the number and frequency of MHA assessments they are asked to do. Some s12 doctors called for an increase to the fee per assessment (generally £170-£200), because of the nature of the work, the seniority of the doctors or the need to attract s12 doctors. In addition, confusions about when fees for undertaking MHA assessments can be paid could potentially create incentives for delaying MHA assessments. A small number of participants argued for incorporating or making undertaking MHA assessments a part of a NHS s12 doctor’s core duties, to improve the availability of s12 doctors and to reduce spending on fees.

**Arranging MHA assessments**
Many AMHPs used local or their own lists of s12 doctors, which included independent s12 doctors and hospital-based s12 doctors to help arrange MHA assessments. Many participants stated that it was almost impossible to involve a GP in MHA assessments. The S12 Solutions app (see below) was seen as a good approach to finding doctors willing to undertake s12 assessments. WhatsApp groups of s12 doctors and AMHPs were also mentioned as means of contacting s12 doctors.

Involving a doctor with previous acquaintance with the person was thought by most to improve the quality and patient experience of the MHA assessment, although it was often difficult to achieve. While AMHPs reported trying to find doctors with experience or specialist skills and to match with gender and ethnicity, as is also expected in the Code of Practice, several said they often simply had to seek out any available s12 doctor.

The interpretation of the MHA 1983 requirement that the two doctors undertaking an MHA assessment must be ‘independent’ varied. Views varied mainly about whether two doctors working in the same Trust could be considered independent. It was thought by most that it was more acceptable to involve two s12 doctors working within a large Trust rather than within small ones, although a small number pointed out the likelihood of influences from past working relationships and hierarchies in all Trusts.

**Reasons for delays in arranging MHA assessments and main difficulties**
Delays in MHA assessments were identified as common by many AMHPs, although a small number of Key Informants stressed that they were not the norm. The COVID-19 pandemic was mentioned as making it generally harder to involve s12 doctors, which could also cause delays. Five other reasons were commonly given:

- AMHPs and s12 doctors not being available
- Shortage of mental health beds
- Waiting for the involvement of the Police or Ambulance Services
- Problems with the person being assessed (e.g., intoxication)
- Problems accessing medical notes.

**Relationships between doctors and AMHPs**
The vast majority of AMHPs and s12 doctors described working relationships between professionals from the other group in general as ‘good, fine, brilliant, positive’. Co-location and regular combined work meetings were mentioned as facilitating good working relationships. However, some tensions were highlighted, such as:

- Roles and responsibilities, particularly in relation to securing hospital beds
- Resolving differences of opinion about the MHA assessment decisions
• Perceived unfairness of the higher remuneration of s12 doctors compared with AMHPs
• Differences in models of practice
• Difficult relationships between Trusts and local authorities (e.g., after the breakdown of integrated arrangements).

Technological approaches to improving the availability of s12 doctors
We asked for views about the Approvals Register and the S12 Solutions app and other local approaches. The Approvals Register was only very occasionally used by AMHPs to help contact s12 doctors; it was mainly used to check that doctors’ s12 approval was up-to-date. The S12 Solutions app, which is being used in about 75% of NHS Trusts, enables AMHPs to contact s12 doctors, who have entered their contact details, any sub-specialisms and availability. Many participants reported that this app helped the smooth running of MHA assessments in three ways:

• Helping to contact s12 doctors, using information about their availability and sub-specialisms
• Making it easier for s12 doctors to claim fees (highly valued by s12 doctors)
• Reducing AMHPs’ workloads, because the use of electronic forms ensures that information is passed on more quickly.

A small number would have preferred the app to be developed and owned by the DHSC and there were also some concerns about how much it costs and whether CCGs, Trusts or local authorities should pay for the app. Also, in one area it was reported that the CCG was rolling out its own app designed to facilitate the finding of s12 doctors for MHA assessments.

Participants also identified several drawbacks to the app:

• The dependence on the internet could limit its application in some areas
• It could potentially mean that AMHPs would be less likely to seek the involvement of a s12 doctor who knows the patient, because of easy access to large numbers of s12 doctors
• Reluctance by some AMHPs or s12 doctors to use the technology
• Some AMHPs may wish to use their lists of known and trusted s12 doctors
• A small number of technical problems had been experienced.

Rotas of s12 doctors
Creating and maintaining rotas, typically of Trust-based s12 doctors, was a common and successful approach to managing their availability. Unpredictable demand, shortages of consultants and covering large areas made it more difficult to manage such rotas. A small number of participants mentioned trying to initiate rotas for s12 doctors available to undertake MHA assessments independently, although these had limited success.

Obliging the NHS to ensure sufficient s12 doctors are available
There was broad consensus across all participant groups in favour of requiring NHS CCGs or Trusts to ensure sufficient s12 doctors were available for MHA assessments, to match the local authority responsibility for maintaining enough AMHPs.

Waiting time standard
Consideration of whether a waiting time standard for MHA assessments should be introduced was recommended by the Wessely Independent Review of the Mental Health Act 1983 (DHSC, 2018). Our participants were predominantly opposed to this idea, although some acknowledged that it
could help establish parity of esteem between physical and mental health. However, many thought it would be difficult to identify an optimal waiting time because of the variability of clinical and social circumstances. Others felt that waiting time standards in general created incentives to avoid breaching the limits, which could lead to negative practices or the neglect of other areas.

Other suggestions to improve availability
Two other suggestions to improve availability were made:
• Improved liaison and more contact between AMHPs and s12 doctors
• Reduce the requirements for s12 approval.

Discussion and conclusion
There are two main findings from the research. First is that the main problem is availability of s12 doctors, rather than overall numbers. This suggests a need to focus on encouraging psychiatrists and other s12 doctors to make themselves more available for doing MHA assessments. Increasing fees and simplifying payment processes may encourage more s12 doctors to do this. Mounting promotion campaigns and cascading encouragement by supervisors and other managers may also increase availability. Including undertaking MHA assessments as a requirement in NHS contracts may also be of value, coupled with the use of rotas, although careful consideration of the impact on workload would be needed. Second, there is currently no real way to tell how many s12 doctors are needed without better information about the numbers of MHA assessments attended by different doctors, in what circumstances. This is a problem of workforce planning.
Chapter 1 Introduction

Reports of difficulty in getting hold of doctors to carry out Mental Health Act (MHA) assessments have been made for over two decades (Greenberg et al., 2002). What is the nature of these reports? What are the options that might improve the availability of these doctors? This report presents the findings of a study which explores the reasons for, and nature of, the difficulties and identifies options for improving the availability of section 12 approved doctors for MHA assessments. The study was conducted in the context of preparations for legislative reform (Secretary of State for Health and Social Care and the Lord Chancellor and Secretary of State for Justice, 2021) and was commissioned by the Department of Health and Social Care (DHSC).

1.1. Background

Section 12 approved doctors (s12 doctors) are practitioners approved by the Secretary of State for Health and Social Care under s12(2) Mental Health Act (MHA) 1983 where they are described ‘as having special experience in the diagnosis or treatment of mental disorder’. Approved Clinicians, who are responsible for decisions regarding patients’ treatment while detained under a section of the MHA, are automatically s12 approved (s12(2A) MHA 1983). Whenever the MHA 1983 requires the recommendations of two doctors, one of them must be s12 approved (Hale, 2017), although both doctors should be s12 approved, unless one has prior acquaintance with the person being assessed. MHA assessments need to establish whether the statutory criteria are met for compulsory admission under s2 (for assessment) or s3 (for treatment). While no data are collected about the overall number of MHA assessments conducted each year, NHS Digital (2020) reports that there were 50,893 detentions under the MHA 1983 in 2019-2020. This present study did not focus on assessments for Guardianship under s7 MHA 1983, for which an analogous assessment procedure is in place. Only a very small and diminishing number of Guardianship orders (105 new orders in 2017-2018) are made annually (NHS Digital, 2018).

Many s12 doctors undertake MHA assessments while working independently and receive a fee for each assessment, which NHS Clinical Commissioning Groups (CCGs) have a legal responsibility to pay (s236 NHS Act 2006). These doctors can be employed by a Trust but undertake MHA assessments outside NHS contracted time. However, many s12 doctors undertake MHA assessments as part of their contracted work for the NHS by a Trust (e.g., during on-call shifts), and do not receive a fee additional to their salary. Other s12 doctors work outside the NHS (often retired GPs or psychiatrists) on a self-employed basis; they can sometimes work solely as s12 doctors and do very little or no other medical practice.

The Independent Review of the Mental Health Act 1983 (DHSC, 2018) chaired by Sir Simon Wessely identified problems in accessing s12 doctors for MHA assessments, as did Approved Mental Health Professionals (AMHPs) in our previous study (Stevens et al., 2018; 2019) when discussing arranging MHA assessments. Similar comments were expressed in the focus groups held by the Care Quality Commission (2018). Furthermore, the Association of Directors of Adult Social Services (ADASS) and NHS Benchmarking (2018) survey of AMHPs found that where delays of over four hours occurred between the receipt of a referral and the assessment taking place, waiting for a s12 doctor was the second most (28%, 74 occasions) common reason for such delays. The most common reason, and one that is very important to note (39%, 102 occasions), was that it was in the best interests of the client/adult to delay the assessment.

This evidence about delays is in the context of increasing numbers of detentions under the MHA 1983, all of which require s12 doctor involvement (except for emergency admissions under s4 MHA 1983). NHS Digital’s statistical report on numbers of patients detained in hospitals in England under the MHA 1983 showed that detentions increased by nearly 50% in the decade to 2015/6, from 43,361 in 2005/6 to 63,622 in 2015/6 (NHS Digital, 2019). In contrast, over the past decade there has
been only a slight rise in the overall number of NHS psychiatrists, from 9,110 in 2009 to 9,318 in 2019 (NHS Digital, 2019).

Investigating and monitoring the accessibility of s12 doctors were both recommended by The Independent Review of the Mental Health Act 1983 (DHSC, 2018) and the National Workforce Plan for Approved Mental Health Professionals (AMHPs) (Department of Health and Social Care, Social Work England, Skills for Care, and Health Education England, 2019). The need for investigation was reiterated by the recent White Paper which set out Government plans for reform of the MHA 1983 (Secretary of State for Health and Social Care and the Lord Chancellor and Secretary of State for Justice, 2021). This is because it is not clear if there is a national shortage of s12 doctors, and/or whether there are other reasons for the reported problems experienced in accessing them for MHA assessments. Two previous literature reviews, including our own (Buckland, 2020; Stevens et al., 2020) found little research presenting s12 doctors’ experiences and opinions about their roles in MHA assessments. Consequently, in addition to a literature review (Stevens et al., 2020), the DHSC commissioned the NIHR Policy Research Unit in Health and Social Care Workforce to undertake primary research, comprising a set of expert interviews to establish the nature of reports about any shortages, and difficulties in accessing doctors, and to explore the impact of organisational contexts for MHA assessments. In addition, the DHSC granted access to the MHA Approvals Register Database, which contains details of all s12 doctors and Approved Clinicians (all of whom are also s12 approved doctors), and an analysis of this data was undertaken as part of the research. We will use the term ‘Approvals Register’ to refer to this database in this report.

Our literature review (Stevens et al., 2020) identified several gaps in the evidence concerning the views and experience of s12 doctors. These gaps related to:

- MHA assessments in relation to the role of the AMHP as final decision-maker
- The training and approval processes required to become a s12 doctor
- The advantages of becoming s12 approved in relation to career progression
- How s12 work is managed in relation to other workloads
- Remuneration levels for MHA assessments and the rules on when, and for which patients, fees can be paid
- Processes of making claims for and receiving payments.

1.2. Research aim and questions
Briefly summarised, the aim of our study was to identify evidence about factors promoting and inhibiting the accessibility of s12 doctors to participate in MHA assessments in England.

We focused on a set of five related research questions:
1. What are the reasons for difficulties in accessing s12 doctors to undertake MHA assessments?
2. What (if any) is the variation in these difficulties across England?
3. What approaches could improve access to s12 doctors to undertake MHA assessments?
4. What (if any) influence does remuneration of s12 doctors for MHA assessments have on availability of s12 doctors?
5. How do MHA assessments fit within s12 doctors’ overall workload (including numbers undertaking this work on a private basis)?

1.3. Structure of the report
Following this introductory chapter, Chapter 2 will describe the methods used for the interviews and secondary analysis. Findings of the different elements of the study are reported in the subsequent chapters:
Chapter 3. Analysis of the Approvals Register
Chapter 4. Motivations and training
Chapter 5. Organisational contexts and s12 doctors’ experiences
Chapter 6. Arranging MHA assessments
Chapter 7. Reasons for delays in arranging MHA assessments and main difficulties
Chapter 8. Approaches to improving the availability of s12 doctors at MHA assessments
Chapter 9. Possible changes that may improve doctor availability

The final chapter will discuss the different factors affecting availability of s12 doctors, will draw some conclusions and present some policy options.
Chapter 2 Methods

2.1. Introduction

A mixed-methods approach was adopted, combining semi-structured interviews (n=52) with an analysis of the Approvals Register (n=9,984), maintained by the four regional Approvals Panels in England.

2.2. Interviews

Semi-structured interviews were conducted mainly using video meeting software (Microsoft Teams, Zoom and Skype). One interview had to be completed on the phone because of difficulties with internet bandwidth, another was undertaken on the phone as requested by the participant. We were interested in participants’ accounts and opinions about a complex and sensitive area, for which semi-structured interviews have been found to be an ideal method (Kallio et al., 2016).

2.2.1. Sample

Semi-structured interviews (n=52) were undertaken, with participants from different professional backgrounds as shown in Table 2.1. The largest number of participants were s12 doctors (n=19). Given the limited amount of research covering s12 doctors’ views and experiences, this was a very important group to include. AMHPs are responsible for arranging MHA assessments and, although there is some evidence about their views, it was also important to obtain their perspectives, so they were the second largest group (n=16).

We also interviewed a wide range of Key Informants (KIs). NHS managers (NHS MGRs) (n=9) play a key role in managing s12 doctors and so their views and experiences were also felt to be valuable. Regional Approvals Panels are responsible for making ‘sure applicants meet the requirements for approved clinician and/or Section 12(2) approval under the Mental Health Act 1983 (as amended 2007)’ (North of England Approvals Panel website, 2021). All four Chairs of the regional Approvals Panels (CAPs) were interviewed; they were felt to have a unique perspective on the overall numbers of s12 doctors and particularly training and approval processes. Other Key Informants (KIs) included Amy Manning, founder of the S12 Solutions app and Steve Chamberlain, Chair of the AMHP Leads Network (names revealed with permission), who have a unique perspective and experience which are valuable to reflect in these findings.

While the numbers of each group of professionals interviewed were fairly small, interviews focused on a very specific topic, which lowers the sample size required to cover a good range of experience (Palinkas, Green and Duan, 2015).

Recruitment took place during the COVID-19 lockdown and social restrictions, so we were unable to recruit as originally planned: it was particularly difficult to recruit advocacy group representatives, for example. However, we interviewed a varied sample, which includes different perspectives and a good sample of the key professionals involved, as shown in Table 2.1.

Table 2.1: Participants' professional background

<table>
<thead>
<tr>
<th>Professional Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>s12 Approved Doctors</td>
<td>19</td>
</tr>
<tr>
<td>Approved Mental Health Professionals (AMHPs)</td>
<td>16</td>
</tr>
<tr>
<td>Chair of Approvals Panel (CAPs)</td>
<td>4</td>
</tr>
<tr>
<td>NHS managers (NHS MGRs)</td>
<td>9</td>
</tr>
<tr>
<td>Other Key Informants* (KIs)</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>52</strong></td>
</tr>
</tbody>
</table>

*Advocacy organisation director; Independent AMHP; S12 Solutions founder; Social Care Manager
Characteristics of participants

We asked participants about their gender, age in groups, and ethnicity, using the census categories (ONS, 2021), as shown in Tables 2.2-2.4.

Table 2.2: Age groups of participants

<table>
<thead>
<tr>
<th>Age group</th>
<th>S12 doctors</th>
<th>AMHPs</th>
<th>CAPs</th>
<th>NHS MGRs</th>
<th>KIs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-40</td>
<td>8</td>
<td>6</td>
<td></td>
<td>1</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>41-50</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>51-60</td>
<td>3</td>
<td>8</td>
<td>2</td>
<td>8</td>
<td>2</td>
<td>23</td>
</tr>
<tr>
<td>&gt;61</td>
<td>7</td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
<td><strong>16</strong></td>
<td><strong>4</strong></td>
<td><strong>9</strong></td>
<td><strong>4</strong></td>
<td><strong>52</strong></td>
</tr>
</tbody>
</table>

Table 2.2 shows that under a third (15/52) were aged 25-40, with a small number (n=5) aged 41-50. About two fifths (22/52) of participants were aged 51-60, with about a fifth (9/52) aged over 60. Age-groups below 60 were distributed fairly evenly amongst AMHPs and s12 doctors, although no AMHPs were aged over 60. We were keen to interview retired s12 doctors, who often continue to work as completely independent s12 doctors.

Table 2.3: Gender of participants

<table>
<thead>
<tr>
<th>Gender</th>
<th>S12 doctors</th>
<th>AMHPs</th>
<th>CAPs</th>
<th>NHS MGRs</th>
<th>KIs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>8</td>
<td>10</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>27</td>
</tr>
<tr>
<td>Male</td>
<td>11</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
<td><strong>16</strong></td>
<td><strong>4</strong></td>
<td><strong>9</strong></td>
<td><strong>4</strong></td>
<td><strong>52</strong></td>
</tr>
</tbody>
</table>

Table 2.3 shows that the group of participants was fairly evenly split between being female (n=27) and male (n=24). However, more AMHPs were female (n=10 vs n=6) and more s12 doctors were male (n=11 vs n=8). This reflects the gender distribution of psychiatrists in England, of whom 48% are female and 52% are male (NHS Digital, 2018). All the AMHPs interviewed were social workers, of whom about 83% are female in England (NHS Digital, 2019), which suggests that male AMHPs may be over-represented in our sample (although there are no data for the characteristics of AMHPs). It is useful to over-sample in this situation, to ensure that a broad range of perspectives is covered.

Table 2.4: Ethnicity of participants

<table>
<thead>
<tr>
<th>Age group</th>
<th>S12 doctors</th>
<th>AMHPs</th>
<th>CAPs</th>
<th>NHS MGRs</th>
<th>KIs</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British*</td>
<td>13</td>
<td>9</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>34</td>
</tr>
<tr>
<td>Any other White background#</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Asian or Asian British - Indian</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Asian or Asian British - Pakistani</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Asian or Asian British - Any other</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Asian background</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5
As shown in Table 2.4, participants were of diverse ethnicities: just under a quarter (12/52) of participants were in minority ethnic groups. However, the sample possibly over-represents White ethnicities, particularly among s12 doctors. In England, 54% of doctors (no data are reported on the ethnicities of psychiatrists specifically) are from White ethnicity groups and 30% are from Asian minority ethnic groups (HMG, 2021). In addition, no s12 doctors and only two AMHPs were from Black British African or Caribbean minority ethnic groups, which reflects the low percentage (5%) of doctors from these groups in England (NHS Digital, 2020a). Just under a quarter of the AMHPs interviewed (3/16) were from Asian (Indian) or Black (Caribbean or African) minority ethnic groups. The AMHP participants were all social workers, so compare well with the overall percentage (23%) of adult social workers from minority ethnic groups, excluding White minority ethnic groups (NHS Digital, 2019). Overall, the sample has included a wide range of experiences and perspectives. However, it is important to remember that with such small numbers of participants from different ethnic minority groups, it is not possible to make any assertions about the impact of ethnicity on participants’ experiences.

Participants reflected on the low numbers of psychiatrists from Black minority ethnic groups in the interviews, so it is a limitation that we were not able to recruit Black African or Caribbean s12 doctors, given the increased likelihood of people in these minority ethnic groups being detained after an MHA assessment (Barnett et al., 2019). However, there are no data on the ethnicity of psychiatrists or s12 doctors and this would be helpful to collect for research but also equality and diversity purposes.

2.2.2. Interview topics

The findings from the literature review (Stevens et al., 2020) and comments from our Unit’s Patient and Public Involvement and Engagement (PPIE) Advisory Group members informed semi-structured interview guides, which were constructed to reflect the perspectives of participants from different organisations and groups. Table 2.5 shows the topics covered by interview guides for each participant group:

<table>
<thead>
<tr>
<th>Topic</th>
<th>S12 Doctors</th>
<th>AMHPs</th>
<th>Chairs of Approvals Panels</th>
<th>NHS MGRs</th>
<th>KIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivations</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training and assessment</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Organisation of s12 work</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Accessing s12 doctors</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Securing the supply of s12 approved doctors</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Development of the S12 Solutions app*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

* Following the census, the demographic questionnaire category was: ‘English/Welsh/Scottish/Northern Irish/British’. One AMHP specified ‘Scottish’ for this category.

# Three of these participants entered their ethnicity as ‘White-European’

#2.5 Table 2.5: Interview topics by participant groups
Approaches to improve access to s12 doctors to undertake MHA assessments

*Only Amy Manning was asked about this. Other participants were asked for their opinions about this app under approaches to improve access to s12 doctors to undertake MHA assessments or when they mentioned this app as a way of accessing s12 doctors for an MHA assessment.

2.3. Qualitative data analysis
Thematic analysis was undertaken, which has been identified as a very appropriate approach to analysing interview data (Braun & Clarke, 2006). All interviews were recorded, with permission, and transcribed in full. The transcripts were entered into NVivo v12 software and coded using a coding frame, which was based on the interview guides. Members of the research team then undertook further coding of different topics, and results were discussed at regular meetings, which evolved our understanding of key elements (Atkinson & Delamont, 2005).

As we described above, the interview guides were developed from the gaps in evidence identified by our literature review (Stevens et al., 2020) and input from our Unit’s PPIE Advisory Group. The further coding undertaken to develop the initial coding frame therefore has balanced the prior theorising with a more grounded approach, which should help avoid the tendency for researchers to find ‘only what they are looking for’ (Ryan & Bernard, 2003: 92).

2.4. Research ethics
All participants were contacted through publicly available information, personal contacts, or through snowballing (in the interviews, we asked for suggestions for other potential participants). Information sheets were given to participants who either emailed completed consent forms, or gave verbal consent, using the consent form as a script. Information is reported anonymously, except for certain participants who were willing to be identified, because of their unique roles. Information sheets made it clear that we would treat their data confidentially, unless they revealed that a participant or someone else has been or is at risk of harm. Approval was obtained from King’s College London (KCL) Ethics Minimal Risk self-registration system (Ref MRA-20/21-17800). The study met KCL ‘minimal risk criteria’ (KCL, 2021), which relate to the characteristics of participants (interviewing professionals and managers) and topics covered by the research (arranging MHA assessments), which were not judged to be sensitive.

2.5. Patient and Public Involvement and Engagement (PPIE)
As noted above, we consulted with the Unit’s PPIE Advisory Group, seeking their comments and views about the research, including interview topics, which were amended as a result. In March 2021, we commissioned the McPin Foundation to arrange a consultation meeting with six PPIE advisors. These advisors either had direct personal experience of s12 approved doctors and assessments or had been in the role of nearest relative or were a family member of someone assessed under the MHA. In this meeting, we presented emerging findings and advisors commented on various aspects, for example, insight into the significance of knowing the s12 doctor doing the MHA assessment, which was very valuable in our analysis and interpretation of the interviews.

2.6. Analysis of the Approvals Register
The Approvals Register contains details of all doctors approved to work as s12 doctors and all Approved Clinicians (which include some other health and social care professionals). The research team was given access to the Approvals Register. The four separate English NHS regions each maintain their own Approvals Register, although they all contain a common core of fields. To the best of our knowledge this is the first time that external analysts have been given this access and we
are grateful for this permission. The Approvals Register contains information about overall numbers of s12 doctors (all medically qualified Approved Clinicians are also s12 approved), their grade, specialisms (and sub-specialisms) and self-reported availability to undertake MHA assessments on a fee-paying basis. The Approvals Register also contains workplace postcodes of hospital doctors and the home address of completely independent s12 doctors.

Each of the four Approvals Panels provided an Excel spreadsheet of their Approvals Register, which were anonymised and combined into a single spreadsheet and exported into SPSS (v27, released June 2020). Frequency and crosstabs have been used to present this data. National postcode data were downloaded from the Office for National Statistics (ONS, 2021), which contain data on the rural classifications and Index of Multiple Deprivation (IMD) related to postcodes. We imported these variables into our dataset, matching with the postcode data in the Approvals Register.

### 2.6.1. Urban-Rural classification

The ONS has divided England into ‘Output Areas’ (OAs), which have at least 40 households or about 100 residents (ONS website), and Lower Layer Super Output Areas (LSOAs) which cover areas having populations of between 1,000 and 3,000. Each OA and LSOA has been classified as Urban or Rural, depending on the population of settlements (conurbations, cities, towns, villages and hamlets): all settlements of more than 10,000 are counted as urban; all others are rural (ONS, 2011). Settlements are further subdivided by reference to the population density of the surrounding area or ‘sparseness’. Classification of areas as sparse depends on measures of the average number of residential addresses respectively within 10km, 20km and 30km. A settlement is classified as within a sparse context if its score on each of these three measures falls within the lowest 5% (ONS, 2011: p11). This results in ten classifications for OAs, reduced to eight for LSOAs by combining Villages and Hamlets as shown in Table 2.6.

<table>
<thead>
<tr>
<th>OA classifications</th>
<th>LSOA classifications</th>
<th>Urban-Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban: Major Conurbation</td>
<td>Urban: Major Conurbation</td>
<td>Predominantly urban</td>
</tr>
<tr>
<td>Urban: Minor Conurbation</td>
<td>Urban: Minor Conurbation</td>
<td></td>
</tr>
<tr>
<td>Urban: City and Town</td>
<td>Urban: City and Town</td>
<td></td>
</tr>
<tr>
<td>Urban: City and Town in a Sparse Setting</td>
<td>Urban: City and Town in a Sparse Setting</td>
<td></td>
</tr>
<tr>
<td>Rural: Town and Fringe</td>
<td>Rural: Town and Fringe</td>
<td></td>
</tr>
<tr>
<td>Rural: Town and Fringe in a Sparse Setting</td>
<td>Rural: Town and Fringe in a Sparse Setting</td>
<td></td>
</tr>
<tr>
<td>Rural: Village</td>
<td>Rural: Villages and Hamlets</td>
<td></td>
</tr>
<tr>
<td>Rural: Hamlets and Isolated Dwellings</td>
<td>Rural: Villages and Hamlets</td>
<td></td>
</tr>
<tr>
<td>Rural: Village in a Sparse Setting</td>
<td>Rural: Villages and Hamlets in a Sparse Setting</td>
<td></td>
</tr>
<tr>
<td>Rural: Hamlets and Isolated Dwellings in a Sparse Setting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Using data from the Department for Environment, Food and Rural Affairs (2018), which breaks down populations across LSOA Urban-Rural classifications, we cross-tabulated the distribution of s12 doctors who are available for MHA assessments on a fee-paying basis by rural classification, based on populations living in each area.
2.6.2. Index of Multiple Deprivation

The Index of Multiple Deprivation (IMD) combines seven distinct measures of relative deprivation in LSOAs (Ministry of Housing, Communities and Local Government, 2019). Each area is allocated a rank from 1, the most deprived, to 32,844, the least deprived area. The seven measures and the weights used to calculate the IMD are given in Table 2.7:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Deprivation</td>
<td>22.5%</td>
</tr>
<tr>
<td>Employment Deprivation</td>
<td>22.5%</td>
</tr>
<tr>
<td>Education, Skills and Training Deprivation</td>
<td>13.5%</td>
</tr>
<tr>
<td>Health Deprivation and Disability</td>
<td>13.5%</td>
</tr>
<tr>
<td>Crime</td>
<td>9.3%</td>
</tr>
<tr>
<td>Barriers to Housing and Services</td>
<td>9.3%</td>
</tr>
<tr>
<td>Living Environment Deprivation</td>
<td>9.3%</td>
</tr>
</tbody>
</table>

We used the ONS (2020b) dataset: ‘Populations by Index of Multiple Deprivation, England, 2001 to 2019’ to identify the 2019 population by IMD. This enabled us to calculate numbers of s12 doctors and numbers of s12 doctors available for fee-paying MHA assessments per 100,000 by the quintiles of the IMD.
Findings
Chapter 3 reports findings from the quantitative analysis. The qualitative analysis of the interviews is reported in Chapters 4-9.
Chapter 3 Analysis of the Approvals Register

3.1. Introduction
This chapter fulfils part of our response to Research Questions 1 and 2:
1. What is known about reasons for difficulties in accessing s12 doctors to undertake MHA assessments?
2. What is known about the variation in these difficulties across England?

3.2. Overall numbers
The Approvals Register contains records of 9,984 s12 doctors and Approved Clinicians. Of these, just 77 are registered as Approved Clinicians, but not as s12 approved doctors, who must be medically qualified. These 77 were made up of Clinical Psychologists (n=40), Registered Mental Health Nurses (n=33), social workers (n=3), and a single Occupational Therapist (n=1). We have excluded these 77 from subsequent analysis, which means that 9,907 s12 doctors are on the Approvals Register, representing 17.6 per 100,000 population in England (ONS, 2020).

3.3. Grades of s12 doctors
Table 3.1 shows that the vast majority of s12 doctors (n=9,019, 91%) are either consultant psychiatrists (n=6,211, 63%) or Specialist Trainee (ST) psychiatrists (n=2,208, 28%), the latter being in training to become consultant psychiatrists. They will almost all be working in hospitals or Community Mental Health Teams (CMHTs). The largest group of the other doctors are Core Trainees (CT) (n=581, 6%), who are completing their initial psychiatry training. All but two of these s12 doctors were in their third year of initial training, which again is almost all carried out in hospitals. Only 215 (2%) of registered s12 doctors are GPs: this small number is consistent with the perceptions of interview participants that very few MHA assessments involve GPs.

Overall, a small number (n=79, <1%) recorded that they were ‘independent s12 doctors’. This means that they are working for themselves, rather than for an organisation. This does not include NHS psychiatrists or other s12 doctors who undertake MHA assessments for a fee and outside their usual NHS work. It is also important to distinguish independent s12 doctors from those working in private hospitals or clinics, who are practising as psychiatrists and treat patients as well as undertaking MHA assessments.

However, it is very likely that this figure underestimates the number of independent s12 doctors. Interview participants suggested that independent doctors were often involved in MHA assessments. There are also indications in the data that this status may not be recorded accurately. In one region an extra 32 s12 doctors indicated their status as ‘independent’ in a field of the database where others entered the organisation they work for. Most s12 doctors entered ‘independent’ in a field intended to record the ‘grade’ (consultant, ST Psychiatrist, GP etc). In the three other regional Approvals Registers there was much missing data from the ‘Organisation’ field. While it is possible that some of these s12 doctors are working independently, we cannot know how many. Thus, it is not possible to determine an accurate figure for the number of independent s12 doctors on the Approvals Register. Table 3.1 shows the grade broken down by whether the s12 doctors worked for the NHS or for the private sector or worked independently.

Table 3.1: Whether s12 doctors work for the NHS/private sector or independent by grade

<table>
<thead>
<tr>
<th>Grade of s12 doctor</th>
<th>NHS or private sector s12 doctor</th>
<th>Independent s12 doctor</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N      (%   )</td>
<td>N      (%)</td>
<td>N      (%)</td>
</tr>
</tbody>
</table>

11
About half (n=2,919, 51%) of s12 doctors were general psychiatrists, who ‘contribute to the management and treatment of adults with mental health problems’ (NHS Health Careers Website), as shown in Table 3.2. Three sub-specialisms accounted for another 30% (n=2,904) of s12 doctors: Old age psychiatry, (n=1,263, 13%); Child and Adolescent Mental Health Services (CAMHS, n=1,186, 12%) and intellectual disability psychiatry (n=455, 5%). A range of other adult sub-specialisms accounted for another 16% (n=1,584) of the other s12 doctors (see Table 3.3 for details), almost half of whom (n=774, 49%) were forensic psychiatry specialists. A small number (n=212, 2%) put their specialism down as general practice (GP) (n=204), prison (n=5) or emergency medicine (n=3).

### Table 3.2: Speciality of s12 doctors

<table>
<thead>
<tr>
<th>Speciality</th>
<th>N</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Psychiatry</td>
<td>4,919</td>
<td>(51)</td>
</tr>
<tr>
<td>Other Adult Specialist Psychiatry</td>
<td>1,584</td>
<td>(16)</td>
</tr>
<tr>
<td>Old Age Psychiatry</td>
<td>1,263</td>
<td>(13)</td>
</tr>
<tr>
<td>CAMHS Psychiatry</td>
<td>1,186</td>
<td>(12)</td>
</tr>
<tr>
<td>Intellectual Disability Psychiatry</td>
<td>455</td>
<td>(5)</td>
</tr>
<tr>
<td>GP, Prison and Emergency Medicine</td>
<td>212</td>
<td>(2)</td>
</tr>
<tr>
<td>Total</td>
<td>9,619</td>
<td>(100)</td>
</tr>
<tr>
<td>Missing</td>
<td>288</td>
<td></td>
</tr>
</tbody>
</table>
### Table 3.3: Other adult psychiatry sub-specialisms

<table>
<thead>
<tr>
<th>Specialism</th>
<th>N</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forensic Psychiatry</td>
<td>774</td>
<td>(49)</td>
</tr>
<tr>
<td>Liaison Psychiatry</td>
<td>290</td>
<td>(18)</td>
</tr>
<tr>
<td>Addictions Psychiatry</td>
<td>134</td>
<td>(8)</td>
</tr>
<tr>
<td>Rehabilitation &amp; Social Psychiatry</td>
<td>118</td>
<td>(7)</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>87</td>
<td>(5)</td>
</tr>
<tr>
<td>Eating Disorders Psychiatry</td>
<td>67</td>
<td>(4)</td>
</tr>
<tr>
<td>Perinatal Psychiatry</td>
<td>61</td>
<td>(4)</td>
</tr>
<tr>
<td>Neuropsychiatry</td>
<td>49</td>
<td>(3)</td>
</tr>
<tr>
<td>Academic Psychiatry</td>
<td>4</td>
<td>(0)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1584</td>
<td>(100)</td>
</tr>
</tbody>
</table>

### 3.5. Availability for MHA assessments

Interviews with s12 doctors and AMHPs suggest that many MHA assessments involve at least one s12 doctor working on a fee-paying basis. The Approvals Register includes information about the availability of s12 doctors to undertake assessments out of hours and for working on a fee-paying basis. Many s12 doctors undertake MHA assessments out of hours as part of their usual ‘on-call’ work, when they are often the ‘first opinion’ s12 doctor. Many assessments require the involvement of a Trust-employed s12 doctor working outside their NHS contract for a fee, or one working completely independently. The availability of doctors willing to undertake assessments out of hours and on a fee-paying basis is an important factor in the smooth arrangement of MHA assessments.

Table 3.4 below gives the distribution of availability in these categories:

- Not available
- Out of hours but not fee-paying
- Fee-paying but not out of hours
- Out of hours and fee-paying

Two fifths (41%, n=4,023) of the s12 doctors on the Approvals Register did not enter availability information. It is possible that some simply had not entered the information, but were willing to make themselves available, although it is not possible to know this from the database. It is likely that many of them would be undertaking MHA assessments during their usual duties. Interview participants described how hospital employed psychiatrists would often decide that patients on wards or coming to clinics needed to be assessed and so acted as ‘first opinion’ s12 doctors. For these MHA assessments AMHPs would be contacted and asked to seek out a second s12 doctor to complete the MHA assessment, who would often be working independently, for a fee.

Just over a quarter (28%, n=2,812) of s12 doctors on the Approvals Register indicated they are available out of hours for fee-paying work. A further 8% (n=766) were available to work on a fee-paying basis but not out of hours. Almost a quarter (n=2,285, 23%) said they would take on MHA assessments out of hours, as part of their NHS work, but would not be available to work independently for a fee.
Just over a third (3,478, n=36%) of s12 doctors indicated they would be available for fee-paying work either within normal working hours (n=766, 8%) or out of hours (n=2,812, 28%).

Table 3.4: Availability of s12 doctors

<table>
<thead>
<tr>
<th>Availability</th>
<th>N</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not available</td>
<td>4,038</td>
<td>(41)</td>
</tr>
<tr>
<td>Out of hours but not fee-paying</td>
<td>2,285</td>
<td>(23)</td>
</tr>
<tr>
<td>Fee-paying but not out of hours</td>
<td>766</td>
<td>(8)</td>
</tr>
<tr>
<td>Out of hours and fee-paying</td>
<td>2,812</td>
<td>(28)</td>
</tr>
<tr>
<td>Total</td>
<td>9,307</td>
<td>(100)</td>
</tr>
<tr>
<td>Missing</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

3.5.1. Availability over the course of the day and week

Information on the times that s12 doctors are willing to do MHA assessments for a fee is also recorded in the Approvals Register. Stated availability is high during office hours (09:00 to 17:00): during this period, an average of 1,947 s12 doctors state they are available. Availability increases slightly in the early evening (between 17:00 and 21:00), decreasing steadily to midnight (from n=2,033 at 21:00 to n=1,088 at midnight). Unsurprisingly, availability is lowest between midnight and 09:00: during this period, an average of 790 s12 doctors indicate they are available to do MHA assessments.

Figure 3.1 shows the changing numbers of available s12 doctors over the course of the day and the week. A very similar pattern of availability is seen over each day of the week, with low numbers available overnight on each day and the greatest availability of s12 doctors appears to be in evenings. However, there are fewer s12 doctors available during the day (between 09:00 and 17:00) and at weekends.
### 3.5.2. Availability by type and grade of s12 doctor

Table 3.5 shows the breakdown of availability across types and grades of s12 doctor. The figures for ‘independent’ doctors have been left in Table 3.5, but it is to be remembered that they do not represent all independent s12 doctors recorded on the Approvals Register, as explained above in section 3.3. This table shows that almost half (n=2,968, 48%) of consultant psychiatrists did not enter availability to undertake MHA assessments out of hours or for fees on the Approvals Register. This compared with about three in ten of trainee psychiatrists (ST n=811, 29%; and CT, n=178, 31%). Surprisingly, small numbers of the other doctors registered as s12 approved, including GPs, also did not enter availability, which is hard to interpret as they would be unlikely to be able to take part in MHA assessments during their NHS duties. As we noted above, many of the s12 doctors who do not enter availability for fee-paying work will be undertaking MHA assessments as ‘first opinion’ doctors as part of their NHS work. The vast majority, about 90%, of s12 doctors indicating availability to work on a fee-paying basis out of hours were consultants (52%, n=1472) or ST psychiatrists (36%, n=1,023). Similar percentages of these senior psychiatrists indicated they would be available for fee-paying MHA assessments, but not out of hours (consultants: 66%, n=509 and ST psychiatrists: 26%, n=199).
Table 3.5: Type and grade by availability

<table>
<thead>
<tr>
<th>Grade and type of s12 doctor</th>
<th>Fee-paying and/or out of hours</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Consultant psychiatr</td>
<td>2,968 (74)</td>
<td>1,258 (55)</td>
<td>509 (66)</td>
<td>1,472 (52)</td>
<td>6,207 (63)</td>
<td></td>
</tr>
<tr>
<td>ST psychiatrists</td>
<td>811 (20)</td>
<td>774 (34)</td>
<td>199 (26)</td>
<td>1,023 (36)</td>
<td>2,807 (28)</td>
<td></td>
</tr>
<tr>
<td>CT psychiatrists</td>
<td>178 (4)</td>
<td>165 (7)</td>
<td>27 (4)</td>
<td>210 (7)</td>
<td>580 (6)</td>
<td></td>
</tr>
<tr>
<td>GP, Prison</td>
<td>33 (1)</td>
<td>69 (3)</td>
<td>20 (3)</td>
<td>93 (3)</td>
<td>215 (2)</td>
<td></td>
</tr>
<tr>
<td>Independent doctor doctor</td>
<td>18 (0)</td>
<td>11 (0)</td>
<td>8 (1)</td>
<td>10 (0)</td>
<td>47 (0)</td>
<td></td>
</tr>
<tr>
<td>Other doctor</td>
<td>9 (0)</td>
<td>3 (0)</td>
<td>3 (0)</td>
<td>2 (0)</td>
<td>12 (0)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4,017 (100)</td>
<td>2,280 (100)</td>
<td>766 (100)</td>
<td>2,810 (100)</td>
<td>9,873 (100)</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>34</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.6. Availability by sub-specialism

It may also be useful to examine the availability of s12 doctors with different sub-specialisms. Securing the involvement of s12 doctors with these different sub-specialisms was identified as problematic by NHS managers and KIs, but also AMHPs we interviewed in this study and previously (Stevens et al., 2018). It would appear to be most informative to include a breakdown only of s12 doctors who indicated availability to undertake MHA assessments out of hours and/or for a fee.

Very similar proportions of doctors with different sub-specialisms indicated their availability for out of hours and/or fee-paying MHA assessments, compared with the overall proportions (see Table 3.5 above and Table 3.6, below). Table 3.6 shows that broadly similar proportions of s12 doctors with different sub-specialisms were available for out of hours fee paying and daytime fee paying and out of hours, but not fee-paying assessments compared with the overall proportions of s12 doctors with these sub-specialisms on the Approvals Register.

Table 3.6: Sub-specialism of s12 doctor by availability (excluding s12 doctors who are not available for fee-paying MHA assessments)

<table>
<thead>
<tr>
<th>Grade/type</th>
<th>Fee-paying and/or out of hours</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Available</td>
<td>Out of hours but not fee-paying</td>
<td>Fee-paying but not out of hours</td>
<td>Out of hours and fee-paying</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>General Psychiatry</td>
<td>1,801 (46)</td>
<td>1,146 (52)</td>
<td>394 (53)</td>
<td>1,578 (58)</td>
<td>4,919 (51)</td>
<td></td>
</tr>
</tbody>
</table>
### ID Psychiatry
188 (5) 105 (5) 40 (5) 122 (5) 455 (5)

### Old Age Psychiatry
550 (14) 277 (12) 93 (13) 343 (13) 1,263 (13)

### CAMHS Psychiatry
609 (15) 255 (12) 92 (12) 230 (8) 1,186 (12)

### Other Adult Psychiatry
781 (20) 357 (16) 104 (14) 342 (13) 1,584 (16)

### GP, Forensic and Emergency Medicine
20 (1) 77 (3) 21 (3) 94 (3) 212 (2)

<table>
<thead>
<tr>
<th>Total</th>
<th>3,949 (100)</th>
<th>2,217 (100)</th>
<th>744 (100)</th>
<th>2,709 (100)</th>
<th>9,619 (100)</th>
</tr>
</thead>
</table>

| Missing | 193 |

### 3.7. Rurality
We linked information about rural classifications and IMD using ONS postcode data (ONS 2021) with postcode data included in the Approvals Register. One caveat about this relates to the amount of missing postcode data in the Approvals Register. Overall, no postcodes were entered for 667 individuals, almost all of whom (n=651, 98%) were from the South of England Approvals Panel area. In all, this represented about a third (29%) of all s12 approved doctors registered by the South of England Approvals Panel. This suggests the findings presented here with respect to rurality and deprivation should be treated with caution. Figure 3.2 presents the distributions of s12 doctors per 100,000 across the eight ONS rural/urban classifications for LSOA (see Methods Chapter).

Overall, as noted above, 9,907 s12 doctors are on the Approvals Register practising in England, which represents 17.6 per 100,000 population of England. Using data about the population distribution across the different urban-rural classifications (Department for Environment, Food and Rural Affairs, 2020), we calculated rates of s12 doctors per 100,000 population across these classifications (see Figure 3.2). There appears to be a higher concentration of s12 doctors in major urban conurbations (21.8 per 100,000 population) compared with ‘villages and hamlets’ (9 per 100,000 population) and in ‘non-sparse’ rural ‘towns and fringe’ (3.2 per 100,000). Figure 3.2 also shows the distribution of s12 doctors who are available for fee-paying MHA assessments. There appears to be a similar distribution of s12 doctors making themselves available for MHA assessments on a fee-paying basis with 6.9 per 100,000 population in major urban conurbations compared with 3.0 per 100,000 population in non-sparse rural villages and hamlets and 1.3 per 100,000 in rural towns and fringes, with much lower figures for the more sparsely populated areas.
Sources: Urban-rural population (Department for Environment, Food & Rural Affairs, 2020, England population 2018) and the Approvals Register

3.7.1. Deprivation

Table 3.7 shows that there are fewer s12 doctors per 100,000 population in the two least deprived quintiles of England, 13.4 and 6.8 respectively, compared with about 20 per 100,000 in the three more deprived quintiles. This pattern was repeated for s12 doctors available for fee-paying MHA assessments, 4.1 and 2.7 per 100,000 in the two least deprived quintiles compared with about 7.5 per 100,000 in the first three quintiles.

Table 3.7: S12 doctors and s12 doctors available for fee-paying MHA assessments per 100,000 population by IMD quintile

<table>
<thead>
<tr>
<th>IMD Quintile</th>
<th>s12 doctors 100,000</th>
<th>s12 doctors available for fees per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20</td>
<td>19.9</td>
<td>7.6</td>
</tr>
<tr>
<td>20-40</td>
<td>20.9</td>
<td>7.4</td>
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<tr>
<td>40-60</td>
<td>19.8</td>
<td>7.4</td>
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<tr>
<td>60-80</td>
<td>13.4</td>
<td>4.1</td>
</tr>
<tr>
<td>80-100</td>
<td>6.8</td>
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The next six chapters present findings from the interview analysis.
Chapter 4 Motivations and training

4.1. Introduction
Improved understanding of the motivations of s12 doctors may help in planning approaches to increase availability. We have grouped the findings in this chapter into three broad themes. First are the main reasons for initially becoming s12 approved, exploring the role that s12 approval plays in psychiatrists’ careers. Second are s12 doctors’ reasons for continuing working as a s12 approved doctor, which mainly relate to their motivation to continue to undertake MHA assessments on a fee-paying basis. Finally in this chapter, we discuss possible reasons s12 doctors might consider giving up s12 status or stopping doing MHA assessments on a fee-paying basis.

4.2. Reasons for becoming s12 approved
Becoming s12 approved was seen by many s12 doctors and KIs as essential to the career of hospital psychiatrists. A very high percentage of psychiatrists are s12 approved, as we note in the analysis of the Approvals Register (Chapter 3: Analysis of the Approvals Register). Undertaking MHA assessments is also viewed as an essential and valuable part of the role. For other doctors the work was more peripheral to their career, but could provide extra experience, seen as useful for general practice.

4.2.1. S12 approved work is integral to the psychiatrist role
All the hospital-based s12 doctors interviewed were clear that becoming s12 approved was an essential part of the job and that it would not be possible to progress as a psychiatrist without being s12 approved:

  I guess it’s mandatory basically, to carry on with your psychiatry training. You don’t have much choice really, if you’re going to do higher training you have to become section 12 approved. S12 11

Furthermore, many s12 doctors and KIs believed that s12 approved work is integral to the role of the psychiatrist. For example, this s12 doctor felt the role was their unique contribution to MHA assessments and the working of the team:

  It actually feels quite integral to what I now do in that it kind of is like your unique contribution to a team or to a particular situation as you are the section 12 approved doctor, so you do what, you know, many others do not do. S12 06

Several s12 doctors believed compulsory admission was sometimes the best or only option for people who are very unwell, showing a faith in the role. However, they all acknowledged the significance of the decision to deprive someone of their liberty, as exemplified by this quote from one s12 doctor:

  If I’m making recommendation for detention, it is because, in my professional opinion, the person is not safe to be discharged in another way. Obviously, I think the depriving someone of their liberty’s, you know, quite major… but a lot of the time there is no other way, you know. S12 04

4.2.2. Broadens experience and interest for non-psychiatrists
For GPs, becoming s12 approved is very much optional and there was no indication of it leading to career advantage. For example, one NHS manager believed that GPs would only be doing s12 work as an area of special interest, and while it could be ‘professionally rewarding’, it would not have any impact on their career as a GP:
It’s interesting, I think many GPs get a bit bored after five years and this is a special interest area. Some GPs, if the opportunities are there, work as clinical assistants in, you know, outpatients or in mental health services, I think it’s professionally quite rewarding if you don’t mind out of hours stuff. But those are the sorts of rewards, it doesn’t lead on to anything. NHS MGR 01

4.2.3. Barriers to GPs becoming s12 approved

Three out of the four regional Chairs interviewed suggested that GPs were generally not familiar with the option to become s12 approved or lacked an interest in becoming s12 approved as there was a general lack of knowledge around the Mental Health Act:

Not many GPs know about section 12, not many GPs are interested in becoming section 12 approved because I think GPs are already busy in their own practices. Some of them who have some interest in mental health conditions, they will apply to (become) section 12. Maybe some retired GPs could apply to become section 12. I think there’s a shortage of GPs who are familiar with the Mental Health Act, and this is universal in the UK, not only in our region. So, we need more GP to become approved really, yeah. CAP 02

4.3. Reasons for continuing working as a s12 approved doctor?

Undertaking MHA assessments was valued as a way of maintaining clinical experience for retired doctors and for psychiatrists undertaking PhDs. It was also seen as a flexible and contained task, which was particularly attractive for independent doctors and as a way of broadening experience for hospital psychiatrists. A small number of hospital psychiatrists and retired doctors were, at least in part, motivated by the potential earnings from fees.

4.3.1. Maintaining clinical experience

Several s12 doctors who took part in the study had retired from their main roles as practising psychiatrists or GPs. These doctors described s12 work as a good and flexible way to continue some part-time work for interest and to avoid complete retirement:

I can’t bear the thought of being completely retired so, it keeps me, you know, it’s an interest that I’ve got. And also, my motto is, work and play basically, you know, I enjoy my play much more if I’m doing work to contrast. S12 01

It’s something that I can do as much or as little of and when I want to and when I don’t want to, so it gives me more flexibility than anything else really that I could, or pretty much anything else that I could do at the moment. S12 15

The three s12 doctors who were or recently had been doing full-time PhDs valued the opportunity to do independent work as an opportunity to maintain a clinical role, which was needed for their ongoing career. This is in addition to the motivation of extra pay described below:

There was a point when I thought I might be sort of almost full time academic and I wanted to do more out of hours section 12, but essentially to keep some clinical experience going. S12 05

4.3.2. A focused task

A small number of s12 doctors valued what one independent s12 doctor identified as the singular nature of working on MHA assessments, addressing a simple (if difficult) question. Another valued
this focused aspect as being less stressful compared with a full time NHS position. This appreciation of a focused role echoed some of the views of AMHPs in our previous study (Stevens et al., 2018):

*What I like about section 12 work is that it’s a very... It’s a single question that is asked of you. Does this person meet the criteria for detention under the Mental Health Act? And, you know, sometimes assessments can be tricky, and you have to sort of spend quite some time.* S12 04

### 4.3.3. Widens experience

Just two s12 doctors valued undertaking MHA assessments because it involved working in different settings, which helped them learn new skills and enabled them to take a broader view of the work. In addition, undertaking assessments as an independent doctor removed a sense of being instructed to come to a particular conclusion about a patient, according to one consultant:

*You see the service from a different point of view, and also, I've just then seen other Trusts, so I've gone to [Trust] and a few others and a couple of private sector establishments and I also think just seeing a diversity of setting and also police stations and seeing a diversity of settings, I also think is good for your training.* S12 08

### 4.3.4. A good way to earn extra income

The extra money earned from undertaking independent s12 work on MHA assessments was a motivation for a small number of hospital psychiatrists and one of the GPs:

*Just it pays per assessment is the rationale and I think chief motivation for everyone to do second opinion section 12 work.* S12 11

*Well, a bit of money, because you [GPs] get double the fee you can go on the rota, which you can’t do if you are not section 12 approved.* NHS MGR 01

### 4.4. Reasons to consider giving up s12 status or stop doing MHA assessments on a fee-paying basis

As noted above, hospital psychiatrists feel they do not really have a choice about maintaining s12 approved status but have a choice about whether and how often to do MHA assessments outside their NHS contracted hours. Independent s12 doctors have complete control over whether to maintain approval and over how much they make themselves available for undertaking MHA assessments. The difficulty of managing their availability, which meant they could be contacted when they were not able or willing to do assessments, particularly at anti-social hours, was a discouragement for some. Others commented that difficulties of securing payment made them consider whether to make themselves available for MHA assessments. A small number of retired doctors found that getting revalidated as a doctor was difficult, which may lead to them not being able to continue as s12 doctors. Some identified changing personal priorities as a reason to stop doing this work.

### 4.4.1. Managing availability

Several completely independent s12 doctors and NHS doctors undertaking s12 assessments on a private basis noted that they were often called when they were not available, some even when the S12 Solutions app was being used (the app shows if a doctor is available or not):
I still get texted frequently in the evening to find out whether I’d be available overnight, obviously they disturb me during the night if I’m not available. S12 01
(Hospital psychiatrist)

However, another hospital psychiatrist was not concerned about being contacted outside the time when they were available if AMHPs were seeking s12 doctors with particular experience or expertise. Where there were such good relationships, this meant that the AMHPs were comfortable in asking and this doctor felt able to accept or decline such work:

There’s no pressure in that, a lot of the time they explain there’s certain reasons why they’d ask one person over another. And it’s, I feel like there is a good enough relationship for them to feel comfortable for asking, for me to feel comfortable saying ‘yes’ or ‘no’. S12 19

4.4.2. Getting paid for independent s12 work
Difficulties over getting paid for MHA assessments undertaken on a fee-paying basis were widely reported (as described in the section on remuneration) and were said to affect hospital-based and independent s12 doctors’ motivation for continuing to do MHA assessments on this basis. For example, this hospital psychiatrist stressed that such frustration would play a role in their decision about whether to continue undertaking s12 work independently:

Should I return to doing nine to five psychiatry … I think the motivation for doing them out of hours will simply go. I guess you must know something about the kind of pipelines of how you get paid and how you get paid… that is a source of frustration for many. S12 11

4.4.3. Difficulty in professional revalidation (for retired doctors working independently as s12)
Three retired doctors (two GPs and a psychiatrist) described difficulties of meeting the requirements to maintain their revalidation as doctors because of the need to provide evidence of medical practice. For example, this former GP described how difficult it was to evidence their practice, because they were outside the relevant organisations:

My main difficulty is not the reapproval but the revalidation because I don’t belong to anybody, I’ve got, theoretically I should have a responsible officer or a designated body, because the Psychiatrists don’t accept me, and general practice doesn’t accept me. I’m no longer an FME [Forensic Medical Examiner], so they don’t accept me. S12 01

4.4.4. Changing personal priorities
One hospital consultant speculated that a doctor coming towards retirement might want to change the focus of their practice, from s12 work:

A possible step back from what you might call frontline mental health work, I think relinquishing section 12 status might be one of those things that you would do, for example, if you were working, if you were moving into…, for example, family-focused interventions and prescribing within an outpatient setting. S12 02
4.5. Training
Most initial training for s12 approval involves a two-day course, which is not usually assessed (Rigby and McAlpine, 2019). In addition, two referees are required to confirm a doctor’s skills and experience. We found very little evidence about the level and type of training required to become s12 approved and for re-approval every five years. We therefore briefly explored opinions of training and what is covered to provide insights into motivations to practise as s12 doctor. Opinions about the lack of assessment for s12 approval and re-approval training are presented in the second subsection. Joint training of AMHPs and s12 doctors was suggested by our previous research as a possible way to improve working relationships: participants’ views on this are also given here. Finally, a small number of participants discussed other requirements for approval and re-approval: two mentioning references and evidence of Continuing Professional Development (CPD).

4.5.1. Availability of training
Two KIs stressed the need for increased training availability to increase numbers of hospital s12 doctors and GPs. One was keen to increase the level of training to attract GPs which the participant thought would give AMHPs more confidence in the level of training undergone by these doctors. This was also supported by two former GPs now working as independent s12 doctors and a psychiatrist:

We were talking about providing more local training, because right now the training happens through the approved mechanisms, either it is the Royal College of Psychiatrists or approved national companies or the section 12 [Approvals] Panels..., who are providing training and that’s not always available at enough frequency and local reach to enable everyone to take part in the training, for example, we have several middle grade doctors, staff grade doctors, who want to become section 12 trained and approved but, you know, training courses are far away and they don’t come up often enough. NHS MGR 07

4.5.2. Level and type of training
Most psychiatrists considered that the s12 training was sufficient because it builds on basic and advanced psychiatric training and clinical work. If this is so, this suggests that a different initial s12 approval training requirement might be needed for GPs and other doctors. This section finishes with lists of suggested areas for further training, and perceptions of the most useful areas of training.

S12 training builds on psychiatric training and experience
Most of the psychiatrists interviewed were happy with the amount of training offered, as their training was usually complemented by the ongoing training pathway towards becoming a consultant: consequently, they suggested that increasing the amount of training would not increase the number of s12 doctors. In addition, they felt that the sizeable amount of experience of daily working with patients subject to or potentially subject to compulsory admission under the MHA before doctors could apply for s12 approval provided a good basis to start working as a s12 doctor:

I think the training and psychiatry gives quite a lot of the sort of experience that you need to be able to do the Mental Health Act assessments, to have the sense of when it’s appropriate to bring someone into hospital under the Mental Health Act. S12 05

However, one also thought that MHA assessments were hard to train for as they were so variable:

We can be sat in a room discussing patients for weeks, but the reality is when you show up to A&E, you, you really cannot necessarily be prepared, so it’s more of an experience thing. S12 04

23
Training for GPs and other non-psychiatrists

Four participants (one KI, two former GPs and one psychiatrist) were keen to increase the level of training, in order to attract GPs, and also to give AMHPs more confidence in the level of training undergone by these doctors. In addition, this KI felt such an increase might make becoming s12 approved more attractive:

If we could definitely do more training, they [non-psychiatrist s12 doctors] would feel more confident. The AMHPs would then feel more confident in their ability. And I think almost kind of making it more attractive and more compelling. KI 01

However, the contrary view was expressed by three former GPs working as independent s12 doctors who felt that the level of training was sufficient and that increasing the requirement might deter GPs from completing the training:

If you have a week's study leave in general practice and you have to, you have to do that with, occupational health, A&E, statutory training, renewal of statutory training for GP, and you'd have to, the section 12, and you'd have to do that for everything, it wouldn't work for portfolio GPs or, or it would pressurise them. So, I think it would put them off. S12 18

Two participants (a s12 doctor and CAP) mentioned the difficulty of developing course content that is appropriate for both GPs and psychiatrists or to account for the processes in different organisations:

I think one of the problems with it is it's not quite GP-friendly enough because it does deal with quite a lot of psychiatry. The consultant psychiatrists who - you know, or the high grade CT5s [Core Psychiatry Training level 5] and so on who are doing it, they're well aware of it and it's a steep learning curve for the GPs who want to do it, much more than the psychiatrists. S12 18

Areas for further training

Many participants identified further areas of training that would have been useful before starting to practise as a s12 doctor. Each was suggested by a small number of s12 doctors and other participants:

Offer Approved Clinician training to all s12 doctors
More focus on conducting the interview
More discussion of case examples (also identified as a useful component of existing training)
Reflection of service user experience
Cultural awareness, particularly the data on disproportionate detentions of black people
Increased reflection in re-approval training
More ongoing support and specialist advice
More access to refresher training and material
More understanding of the relationships between mental health and learning disability or autism

Most useful topics covered by s12 training

These were identified as the most useful topics by s12 doctors, CAPs and KIs:
4.5.3. Assessment in s12 training

Most participants thought that no assessment of learning was required, although one NHS manager, who was also a s12 doctor, mentioned pre-course tests that need to be passed before being allowed to access the online course proper. However, these were an adaptation of the usual course due to Covid-19 restrictions, so may not be continued when/if courses return to being face-to-face following the Coronavirus pandemic. As noted above, several s12 doctors argued that there was no need for any assessments in s12 training because it followed on naturally from psychiatrists’ general training and ongoing practice. This idea was also used to support the current level of s12 training. For example, this s12 doctor felt that having two referees and the ongoing scrutiny of medical recommendations made assessments unnecessary:

*I think the fact that you’ve got two referees who are working, you know, contemporary, working with you, is probably sufficient... I’m not sure it [written assessment] would have any major value... There’s a consultant, you are on the rota and your job is to look at all the medical recommendations that come in and to make sure that they have adequately fulfilled what’s written on there. So, in terms of the composition of your assessment, that’s scrutinised all the time.*  S12 15

Another psychiatrist felt that pitching the assessments would be difficult, in striking a balance between a potentially humiliating and career-threatening pass/fail approach and a meaningless tick box exercise:

*If you had a heavy pass and fail test at the end of the mandatory training, I think that would be quite threatening.... On the other hand, in terms of e-learning, medicine has become a little bit trite, because it becomes a tick box exercise.*  S12 18

However, two s12 doctors supported the idea of having a supervised assessment after initial s12 approval, which they thought would be a good way of supporting s12 doctors in applying knowledge learned on the course. This would match the requirements for GPs and other non-psychiatrist s12 doctors, who must complete two MHA assessments under the supervision of a ‘senior’ s12 doctor after their initial course (Winterhead Website, 2021):

*If anything, I think a supervised, you know, one off supervised, you do it with someone who is mental health approved and do it that way. I think testing of knowledge, like I don’t think that would [work], because it’s the application of the knowledge.*  S12 16

Joint training for AMHPs and s12 doctors

Almost all participants were broadly positive about the idea of joint training between AMHPs and s12 doctors: some also mentioned the value of training with other professionals, such as Occupational Therapists. However, none raised this as an idea to improve training, before being asked about it. Many focused on the advantages such training could bring in developing good
informal relationships between AMHPs and s12 doctors and to promote mutual understanding of roles and perspectives:

I think that AMHPs being involved in that, and section 12s being involved in AMHP training you need that kind of cross contamination really to improve it. We’re big into trying to promote joint training here and it’s beginning to take off. AMHP 06

However, one AMHP was of the view that this would not ‘make a difference’ (AMHP 09) and two s12 doctors thought that improving mutual understanding was of limited importance, compared with organisational barriers and a ‘clunky’ system, which meant for this participant that joint training was not a priority:

I guess you’d get a mild improvement if they understand each other’s role a bit more, but I don’t think if I could pick one thing to sort out the clunky system, I don’t think I’d pick that. I mean I guess, if you can’t pick any of the other things that I want to pick, then I’d pick that. S12 11

4.5.4. Other approval requirements

In addition to training, those applying to be s12 doctors are expected to provide two referees, both initially and when renewing their approval, when they also must evidence their Continuing Professional Development (CPD). A small number of s12 doctors and KIs questioned the ability of referees to provide good feedback about the performance of s12 doctors. In addition, a small number of KIs and one CAP felt that more CPD should be required for re-approval of s12 status.

Referee requirements

One NHS manager questioned the validity of the approach to providing references for s12 doctors renewing their approval. They felt that there was no way to check the performance of s12 doctors or their willingness to undertake MHA assessments, but that there were never enough reasons not to supply the reference:

I’m quite sort of thorough about things like this and sometimes I will ring the clinical director and stuff. But really, you know, it’s never going to be something that, I might have concerns about the doctor for other reasons as a medical manager but knowing enough to write in a document that I think that they’re not good enough to know how to act the Mental Health Act when they’ve been doing it for the last 15 years, I think it’s just pointless if I’m really honest. NHS MGR 03

Specific s12 CPD required

Two Chairs of Approvals Panels and a Trust Medical Director suggested that requiring some specific CPD related to s12 work as part of professional revalidation would be of value in ensuring the quality of s12 doctors. One linked this idea with a belief that five years was too long a gap between induction and refresher training:

I think the idea that you have one day every five years to refresh compared to AMHPs who have about three days every year, I think is inadequate and I think what I would like is that the GMC [General Medical Council] at appraisal would identify that people need to do appropriate CPD in relation to their work as a section 12 doctor. CAP 01
Chapter 5 Organisational contexts and s12 doctors’ experiences

5.1. Introduction

Interview participants were working in a variety of organisational contexts, including areas with integrated Community Mental Health Teams, usually set up through agreements under section 75 (s75) of the National Health Service (NHS) Act 2006, which enable pooling of budgets between the NHS and local authority and the secondment of social workers to multi-disciplinary mental health teams. Others worked in areas that had separate mental health social work teams, managed by the local authority. These included three areas in which mental health social work had been recently disaggregated from the NHS, after the breakdown or dissolution of s75 agreements.

Three themes emerged relating to the organisational context. First was the importance of the relationship between NHS Clinical Commissioning Groups (CCGs) and NHS Trusts, which affected financing the s12 doctor service. Second was the impact of integration and co-location on working relationships and the organisation of MHA assessments. Governance of s12 doctors’ work was a third theme, which was mainly a Trust responsibility for hospital doctors; governance of independent s12 doctors was identified as problematic.

5.2. Organisational responsibility

Different arrangements appeared to be in place for commissioning and funding s12 services. Under s236 NHS Act 2006 CCGs have a responsibility to pay fees for s12 doctors doing MHA assessments. One important distinction was the use of the budget for these fees. In some areas, this is held by the CCG from which s12 doctors would claim their fee directly, whereas, in others, the CCG passes the budget for managing MHA assessments to the Trust(s). This became important for managing the balance of NHS and independent s12 doctors as described below. Where the CCG holds the budget, this was felt by a s12 doctor and two AMHPs to highlight confusions about the organisational responsibility for funding MHA assessments. Where the CCG passes the budget for providing MHA assessments to the Trust(s), this creates an incentive to limit the involvement of independent s12 doctors, particularly if there is no specified sum ring-fenced for paying fees:

> The money comes from the CCG but it, yeah, for now it’s not badged as section 12 remuneration money, it just comes across in the contract and the block money. We can’t say the CCG gives us X amount of money for section 12 doctors. That’s now managed in the mist of time internally and we’re managing the cost pressures of that, whereas in other places where it never came across to a Trust, the CCG are managing those cost pressures. NHS MGR 02

5.2.1. Health and social care integration

We heard a variety of views from participants on what they considered to be the optimal mode of joint working between local authorities and Trusts. Arguments were made for integration by some, while others stressed the importance of co-location and others prioritised improved liaison between health and local authority partners. In each case, participants were suggesting that their preference would have a positive impact on the arranging of MHA assessments.

Integrated working

In the view of one Medical Director, integration had the value of fostering understanding between professionals about available resources:

> I think that AMHPs and psychiatrists working in the same Trust, [...] having the same terms and conditions of service, being integrated within teams, makes a big difference because then they become, you know, they understand each
other, and when they run an AMHP duty worker rota they know what it’s like in the Mental Health Trust, what the availability is, what the systems are like, so they are able to have a better understanding. NHS MGR 07

Furthermore, one AMHP identified how the withdrawal of the local s75 arrangement had made informal conversations and formal referral processes more difficult, which could have the effect of making it more difficult to identify and recommend the least restrictive option:

*You kind of have to wait for the official referral to come in before starting to have these conversations. Before, those conversations were just constantly there within the teams at all times to think about, you know, when should a doctor try and see somebody, what’s the role, I don’t know, of the team and thinking about least restrictive options before thinking about Mental Health Act assessment. So, yeah, it seemed like it was potentially better for trying to avoid Mental Health Act assessments when it was integrated.* AMHP 10

However, a Medical Director, with experience of two of the three relevant local authorities withdrawing their social workers from integrated Community Mental Health Teams, said that there was still a ‘reasonably robust pathway’ (NHS MGR 06) where AMHPs from these authorities were concerned. By this, the participant was referring to the fact that the team aimed to make a home treatment offer and assessment at the same time as the assessment for detention. They suggested that this probably happened 80 to 85% of the time – the rest of the time the person was being detained without the home treatment assessment being made.

**Co-location (non-integrated)**

A small number of AMHPs and s12 doctors stressed the value of co-location but identified drawbacks to integrated arrangements. Co-location was thought to facilitate early conversations and good relationships between s12 doctors and AMHPs, without the perceived problems associated with the management of integrated teams, where some AMHPs reported feeling unsupported:

*Our co-location to me is more important than integration. I think you can do lots of things if you’re in the same space, you don’t have to be employed by the same people or run by the same people. And, actually, sometimes creative tension is really useful, and I think it’s very underrated, because I think as soon as you come under the umbrella of the NHS with its very hierarchical kind of monolithic structure, it means that if we were subsumed into it, our independence would be reduced and then suddenly it just becomes a process, not like something more meaningful.* AMHP 06

**5.2.2. Governance of MHA work**

Several participants from different groups thought there was a lack of governance of s12 doctors’ work in MHA assessments. While one concern was raised about the governance and quality assurance for hospital-based s12 doctors, the governance and quality of independent s12 doctors were considered by several participants in all groups to be much more of a problem. For example, this CAP felt able to address concerns about the performance of s12 doctors employed by the Trust, even for work undertaken independently. However, they believed it was not possible for managers or AMHPs to identify and manage the performance of s12 doctors working outside the Trust:

*If a doctor who works for my Trust, there are issues around their Mental Health Act assessment work, whether it’s in hours or out of hours work, whether they do it independently, I have somewhere to go in relation to saying we’ve got concerns*
Another independent s12 doctor noted that there was no external monitoring of the number of MHA assessments undertaken by individual s12 doctors in a day, which could lead to unsafe practice, in their view:

*You can do back-to-back assessments all day, you could earn eight or nine independent assessments. I actually don’t think that’s safe, particularly.* S12 18

One KI suggested that the correct completion of paperwork, which was seen as part of the ‘contract’ with the independent doctor, after an MHA assessment would be one way of improving governance. One independent s12 doctor also argued that the formal administrative examination of written assessments undertaken by Mental Health Act Officers (MHAOs – see below) providing valuable ‘paperwork’ or administrative oversight was probably the only existing way that patients’ legal rights were protected:

*The only scrutiny I would have would be the scrutiny of the paperwork because that’s done by the Trust that the patient being treated ends up going to.* S12 15

One NHS manager and several s12 doctors thought that the only means of governance of s12 doctors working completely independently, other than by reporting serious misconduct, was through AMHPs not asking them to do MHA assessments, if they felt their skills were not very good:

*I think if there was something very serious in anything they do or said during an assessment, they would report it. But if somebody was, they just didn’t feel that they were a doctor that had skills that they would want, I think they just stop using them.* NHS MGR 02

However, this raised a further query for this KI about whether to pass on concerns about an independent s12 doctor to neighbouring Trusts and whether the Trust could be sued for these decisions not to use certain s12 doctors:

*There was a debate amongst my colleagues about whether we should inform other people about our concerns [about an independent s12 doctor]. And there was concern that we could be sued due to restriction of trade, if we were sharing just general ad hoc concerns, which could be seen as gossip.* KI 02

A similar concern was expressed by an independent s12 doctor, who identified what they thought was a lack of transparency about decisions to use independent s12 doctors for MHA assessments: they felt that these decisions could be influenced by what they termed ‘politics’:

*I’ve heard conversations of doctors saying, ‘well that AMHP has done this,’ something negative or sometimes positive. And then I’ve heard AMHPs say, ‘well that doctor’s done this and I’m not going to use them for section 12 work again.’ There’s a lot of politics on who gets chosen and things like that.* S12 19

**5.2.3. Lack of data**

Several KIs, CAPs and AMHPs were concerned about what they saw as a lack of data on MHA assessments. Such data would be useful to help understand the level and causes of delays; this
comprised the numbers of MHA assessments undertaken by NHS s12 doctors as part of their contracted work, NHS s12 doctors working outside their contracts for a fee, or independent s12 doctors. Finally, this kind of data was thought to be useful for examining variations round the clock. Several of these participants commented on the potential for the S12 Solutions app to support this kind of data collection:

It depends on the time of the day that you want them. When - I think about three months into having the S12 Solutions app, I did an audit of the data that they had. I was particularly interested in the period of time from midnight to 6am. AMHP 07

5.3. Working as a s12 doctor

5.3.1. Support from colleagues and management in s12 role

Hospital psychiatrists described receiving good support from colleagues and supervisors and their Trusts in the form of Mental Health Act Officers, although some identified areas where increased support was needed. However, independent s12 doctors had to make their own arrangements for support, which some found challenging. While this was particularly important for doctors working outside the NHS, hospital-based s12 doctors undertaking MHA assessments on a fee-paying basis also reported this lack of support.

Professional support for hospital s12 doctors

Several NHS hospital psychiatrists were positive about the professional support they had for immediate advice and for ongoing supervision, and two NHS managers mentioned that support for MHA assessments is provided through the ‘usual peer and supervision’ (NHS MGR 01). However, one of these psychiatrists, while valuing the support provided generally, suggested that less support was available for MHA assessments taking place in A&E or at police stations (which are formally outside the NHS remit):

I suppose if we had something we [S12 16 and supervising consultant] could discuss it there and then, or I get a weekly supervision with my consultant, talk about a wide range of issues. Sometimes that has included Mental Health Act related topics, and then we also get a monthly on-call supervision group. So Mental Health Act assessments are not in my day job, so on my on-calls where I’m just covering A&E out of hours, or for a police station, that’s less well supported. S12 16

Two psychiatrists discussed the need for specific, formal or informal, feedback about their performance in MHA assessments, stressing the importance of this for improving practice:

I’ve done, God knows how many Mental Health Act assessments I’ve done in my life .... Have I ever been given feedback on any of them? None, nobody would have said to me, ‘Actually that was a really nice piece of work, I loved the way you engaged the family,’ or said to me, ‘I thought you were really quick to make a decision and it was ill-informed,’ you know. NHS MGR 03 (manager and s12 doctor)

Mental Health Act Offices (MHAOs)

Mental Health Trusts have a Mental Health Act Office (MHAO), whose staff ‘provides support to the mental health services within an organisation by providing advice, completing the administrative tasks relating to the MHA 83 and by monitoring that the requirements of the legislation are adhered to’ (Livewell Southwest, 2021). Many s12 doctors and KIs from the NHS and one AMHP stressed the importance of the MHAO staff in checking assessments and in providing information and support.
For example, this KI described how the MHAO in their Trust provided legal updates and advice for Trust s12 doctors and other professionals (but not external independent s12 doctors):

> We’re reliant as well on the ongoing communications from the Mental Health Act Office about what the latest cases are and the implications of them... They’ll provide advice to anyone about anything to do with the Mental Health Act: so, nurses; bed coordinators; managers; section 12 doctors... and they’re very responsive. NHS MGR 05

**Lack of support for independent s12 doctors**

Support for hospital psychiatrists working as independent s12 doctors was limited, although this was seen by some psychiatrists as being acceptable as they were working on a similar basis to s12 doctors working outside of the NHS completely:

> In terms of doing section 12 second opinion work, I mean there is no support system whatsoever, I mean the whole point is that you’re legally independent. So, it is a very, I suppose in some ways a strange system, you’re just by yourself, you just do whatever you want and that’s it, there’s no support, there’s no sort of challenge system or whatever, there’s no way you’re called up if you’re doing it badly, that’s just it, you are an independent practitioner going about your business. S12 11

The sense that independent s12 doctors were left unsupported was also a commonly held view among completely independent and some hospital s12 doctors working on MHA assessments independently, although again, this was often viewed as natural or inevitable, given their independent status:

> As I say there is no real kind of formal organisation around the section 12 doctor, it is a very, very, very kind of shaky thing at all levels which has always felt strange to me. S12 11

> So, we don’t get access to the same assistance and provision that the Trust employed doctors do. But that’s the nature of being self-employed and independent. S12 12

However, this was not a universally held view. One s12 doctor, who worked completely independently, felt they did not need support:

> Well because I’m not dependent, I mean I’m not a GP so I’m not interacting in their service that I’m giving for the patient in that respect. So, I don’t really require any support from colleagues. S12 01

In the absence of formal support, support from peer groups was identified by two independent s12 doctors as valuable:

> I’m in a peer group just of section 12 doctors and obviously we meet four or five times a year, but also, I contact them whenever I feel like it. So, if I have had a particularly difficult case or I don’t quite, you know, know if I, just wanted to think it over, I often will contact them and talk it through. S12 15

In addition, informal support, advice and feedback from AMHPs were another source of support (identified by two s12 doctors):
I think the independent work is quite good because you generally get a sense from the AMHPs that you’re working with, they sometimes do give you feedback about the quality of your assessment or the quality of what you’ve written that I find very helpful. S12 08

Access to medical records

It was widely remarked that independent doctors at MHA assessments do not have access to the medical records of the patient. This was believed by two s12 doctors to make it more likely that the second opinion doctor (independent s12 doctors usually perform this role) would agree with the first opinion. This then extended to the independent doctor not being able to write up their notes on the Trust’s system, a problem accentuated where two independent doctors were making medical recommendations:

So, we then end up with a most ridiculous system where the – we – the AMHP says – particularly if two section 12 independents have made an assessment, they have no way of recording their findings on the hospital system, so the only way is a fudge to write a Word document, which I’ve just done yesterday for one I did, send it to the AMHP who will then paste it to the system and that’s totally ridiculous. S12 18

In terms of optimising MHA assessments, it was suggested by one s12 doctor that the assessment process could be made ‘smoother’ if independent doctors had access to patient records, although this participant acknowledged that there would likely be regulatory barriers to this happening (S12 20).

One s12 doctor questioned the value of a second medical recommendation without access to the medical notes, as this put the value of the second opinion in doubt, although this was the only participant who made this point:

I simply don’t think in the real world it adds that much value because I don’t think people are that inclined to disapprove the first opinion because I think that they, you know, I think that they just don’t have enough information to disagree, and the legal lines are never going to be breached. I think a much more preferable system would be to have only one opinion but a quicker and earlier right of appeal, that the patient, within the first 24 hours or within the first 48 hours. And then to have the benefit of a few hours for whoever’s going to manage the appeal to read all the information available and have more time looking at it all. S12 11

5.3.2. Amount of s12 work

Most s12 doctors (including hospital and independent s12 doctors) appeared quite happy with the number and frequency of s12 assessments they were asked to do. They valued the flexibility of being able to choose whether to take on an MHA assessment, as we noted above. None of the hospital psychiatrists we spoke to felt they had to do too many MHA assessments during their NHS shifts. However, a few independent s12 doctors were concerned that AMHPs were not contacting them enough because they had perhaps refused to take on some assessments or because Trusts preferred to use their own doctors for financial reasons:

We struggle a bit sometimes to be honest, I think we do a bit. There’s not enough, we don’t get necessarily a slice of the work from the Trust because they prefer their own doctors to do it, obviously it’s financial drivers they like to keep it in-house really. S12 12 (Independent s12)
Balancing s12 work with NHS role?
Hospital psychiatrists expressed very little concern about balancing s12 work with other duties. One consultant reported managing their s12 independent work by making sure that their availability for independent work was outside their normal working times as a consultant:

> So, for me, the balancing bit never was an issue. I don't normally - the vast - I would say that 85% of my work happens during the weekends, during daytime, so it doesn't really have an impact on my sort of normal role. S12 20

However, one NHS manager was aware of how difficult it could be to respond to calls to do an urgent MHA assessment in the middle of a shift. This reveals a tension with management expectations that consultants and other hospital psychiatrists would be the first s12 doctor on MHA assessments involving patients they were treating, as noted above:

> It can be really difficult if you’ve got booked activities. So, if you’ve got a booked Outpatient Clinic and something comes up as an emergency. So, it’s really difficult if it is a same-day-needed-now type response... You have to book things in. You can’t leave lots of gaps for Mental Health Act assessments because they’re not that frequent or that predictable. NHS MGR 05

5.3.3. Remuneration
In addition to debates on the size of the fee, three further aspects of remuneration were of importance to participants from all groups. First, many participants were concerned about ambiguities over the rules about whether fees for undertaking MHA assessments can be paid. This was reported to lead to confusion and also to creative incentives for delaying MHA assessments. Second, was the problems many s12 doctors had experienced in getting fees paid, which they linked to complexities in organisational responsibility. Some s12 doctors felt discouraged from making themselves available to undertake MHA assessments independently by the extra work required to secure payment. Finally, a small number of participants questioned whether continuing to pay fees for MHA assessments should continue.

Amount
Most s12 doctors were being paid between £173 and £183 per assessment. Opinions were fairly evenly split between AMHPs thinking that the fee was too high, about right or expressed no opinion. Similar mixed views about the level of fee were expressed by members of the consultation group of people who had experienced being assessed. No AMHP argued for increasing a fee, although some understood the need for increasing it to ensure the continued availability of s12 doctors:

> And I suppose the increase in fees makes sure plenty of s12 doctors are still around. AMHP 01

Opinion was also fairly evenly split amongst s12 doctors between being satisfied with the fee and feeling that it should be increased. Unsurprisingly, none of the s12 doctors felt that the fee was too high. Several of the KIs argued for an increase, partly because of the seniority of the doctors, the need to attract s12 doctors and, as many s12 doctors also noted, the fact that the fee had not been increased for several years:

> I think the fee has been fixed for 10-15 years, which is wrong ... It’s £173.57 per assessment ... and that hasn’t changed. It hasn’t gone up with inflation or anything. S12 18
A small number (four) argued that the fee should be higher, considering tax and the amount of time some assessments take. One was of the view that locum clinical work was a better and more predictable way to earn extra money. They noted that travel time can lower the hourly rate for the assessment, as illustrated by this s12 doctor:

\[ \text{The fee is £173.37, so if you’re a higher rate taxpayer, you pay 40% Tax and then say 9% National Insurance. So, you end up being paid, you take home something like, what £85. And then depending on where you are geographically, you might travel for an hour, see the patient and make an assessment for an hour and a half and then travel for an hour. So that would be three and a half hours work for £85, so you would end up being paid like £25 an hour, I think. S12 08} \]

Four s12 doctors and several AMHPs mentioned indemnity as a problem, in relation to overall remuneration and as a source of confusion about practising as a s12 doctor:

\[ \text{It’s an interesting area because one, we have to get medical protection for that, and, our Trust have stopped doing it [MHA assessments in police stations] because we get paid for it, so it’s classed as kind of private work, so you have to get specific indemnity insurance to do that, so that’s a little bit of a barrier. S12 16} \]

**Ambiguities over when fees can be paid**

Many s12 doctors, KIs and AMHPs raised the complexities and ambiguities over when fees were available. The general principle was that s12 doctors could not be paid a fee for work that they should be covering in their NHS work. A small number of s12 doctors suggested that this approach encourages s12 doctors to wait until their shifts have finished to undertake MHA assessments, because they can then keep the fee. This can cause delays, as noted by one participant, in correspondence after their interview:

\[ \text{As [Trust] staff cannot claim during the day, they are often reluctant to do MHA work then particularly if they are also scheduled to carry out other work for the Trust when they are on the [Trust] rota. This leads to confusion and delay in assessments. S12 18} \]

Several s12 doctors were clear that fees for MHA assessments could be claimed if the assessment took place in a police station, even if this was during the s12 doctor’s NHS on-call shift:

\[ \text{We’ve clarified as NHS doctors that we’re not covered... it’s not part of our job description to see people at the police station. So, if the police liaison nurse has any concerns about someone’s mental state, they can refer for a Mental Health Act assessment and... the AMHP will, is allowed to call the registrar and call the NHS doctor because they’re available, but they act in an independent capacity. S12 04} \]

Several AMHPs pointed out that they had to ‘sign off’ for the s12 doctors fee, which was sometimes problematic and confusing in the light of these ambiguities over whether a fee was payable. For example, whether fees were payable for assessments taking place in s136 situations was confusing for two AMHPs, who were unclear about whether s12 doctors had to make up the time taken for the MHA assessment. One of these was reluctant to investigate this too deeply, for fear of reducing the number of s12 doctors available to do MHA assessments:

\[ \text{Think there’s some ambiguities around health-based 136s because obviously the GMC guidance is that they shouldn’t be claiming for those assessments because it’s on a hospital site and, therefore, could be seen as part of their day-to-day work.} \]
Again, it’s an area that we’ve kind of not really explored too deeply because my worry is that we then lose the doctors willing to come and assess for 136s, if I’m honest. AMHP 14

Fees paid when no assessment undertaken
Several s12 doctors and AMHPs mentioned that s12 doctors get paid fees even if the assessment cannot take place, which one AMHP felt was not justified, although they approved of the practice in another Trust of paying half a fee if the patient was not available:

I’m thinking of one particular client ..., just from last week, we have made three attempts to assess under the Mental Health Act and he hasn’t been at home. So that’s six medical examination fees that are being claimed for somebody who hasn’t been seen which, to me, just doesn’t seem very cost-effective. AMHP 07

Again, the picture appears to be variable. One independent s12 doctor gave an account of travelling a long distance, only to find the patient had disappeared, which meant they were not paid:

Some authorities, [City], which is about an hour’s drive before I get there, say, ‘Oh you’re not needed, the patient’s disappeared, so you get nothing at all.’ If you turn up and they’re not there then that authority says, ‘Oh we’re not paying you because you haven’t done the assessment.’ S12 12

Difficulties in securing payment
Many of the s12 doctors we interviewed discussed difficulties in getting paid for independent s12 MHA assessments. Clarifying the rules, particularly about out of hours payment and simplifying the administration process were very commonly identified as areas for improvement in order to increase the supply of independent s12 doctors.

Many s12 doctors described this as the most difficult aspect of working as an independent s12 doctor, which for some discouraged them from doing MHA assessments on a fee-paying basis. Several AMHPs also raised this as a reason for the problems about availability of s12 doctors. Securing payment for MHA assessments often meant much work chasing organisations and long delays before payments were made, particularly for assessments carried out away from the s12 doctor’s usual Trust. As a reaction, one hospital psychiatrist reported being reluctant to accept independent s12 work if it was based at a particular location which took patients from different parts of the country making the task of being paid very difficult:

I think probably sometimes even for me, if the AMHP phones me up and says, you know, ‘This is somebody from [large, distant city],’ I might say, ‘No’. You know, it’s not worth me doing that ‘cause it’ll take me weeks and months of headaches and emails to get the money and there’s no point. S12 15

Continue with a fee?
Several KIs and AMHPs felt that one possible solution would be to make undertaking s12 assessments part of NHS doctors’ main duties and phase out fees for MHA assessments. They felt that properly protected time would be needed for this:

I just worry that if it was suddenly stopped, we’d have even bigger problems. It could be phased out, that might be a good thing, but that would have to come with protected time so that people were getting paid, as it were, to do that as part of their job. KI 05
However, one NHS manager thought that allowing flexibility for s12 doctors to undertake MHA assessments independently, when and where they wanted (and therefore on a fee-paying basis) increased the diversity of s12 doctors:

*And you have doctors that is just, you know, that is their job they are independent doctors, that’s how they make their living. And I think as a consequence of that you get a really mixed skill set and you get a really interesting group of people especially when you think about like diversity and gender, ethnicity and all of the different specialisms by allowing that flexibility in the system and let doctors have options about whether or not to do section 12 work. NHS MGR 06*
Chapter 6 Arranging MHA assessments

6.1. Introduction
This chapter explores the different ways that AMHPs use to secure the involvement of s12 and other doctors for MHA assessments. The different factors associated with involving doctors with prior acquaintance and ensuring that doctors with appropriate specialist knowledge are also covered. The chapter finishes with a discussion of how the MHA requirement for the two doctors undertaking MHA assessments to be independent is interpreted.

6.2. Ways of arranging MHA assessments
AMHPs used several different approaches to arranging an MHA assessment. The choice of approach was often dependent on the specific context of assessments being undertaken. An important difference related to where assessments took place. The main approach used by AMHPs was simply to contact s12 doctors directly from a NHS Trust, often helped by a rota of s12 doctors within the Trust. However, many assessments are initiated by hospital-based psychiatrists, who often act as ‘first opinion s12 doctors’, undertaking their assessment and making a recommendation, before the AMHP arrives. In these circumstances (which are mainly in hospital), the AMHP often must arrange for another, independent, s12 doctor to provide a second opinion and recommendation. Many assessments undertaken in the community are undertaken jointly (that is, with the AMHP present), requiring the AMHP to arrange for two doctors (mostly, in the experience of this study’s participants, these are both s12 doctors) and to coordinate practical arrangements. Initially, this section explores the ways for arranging a joint assessment.

6.2.1. AMHPs contacting s12 doctors directly from a NHS Trust:
This was mentioned as the main approach by many AMHPs and by several other participants. As we note in other sections (see Chapter 8: Approaches to improving the availability of s12 doctors at MHA assessments), rotas for s12 doctors facilitated access:

[The NHS] provider has instigated a sort of section 12 rota. So, they volunteer two doctors every day, doesn’t work every day, but in theory they have two doctors that would be able to do Mental Health Act assessments for their cohort of patients, i.e., 24 and above. [...] We can ring off that rota, nine to five. Bearing in mind, you know, our average activity is around 20 assessment a day, 18 or 20, the most we’ve had Monday is 36, the least is around 11 or 12, we are off our feet. AMHP 03

However, one AMHP said that they would not use doctors from a Trust rota partly because they would often not be available but also to protect their own autonomy in choosing the most appropriate s12 doctor:

Part of the AMHP role, as far as I’m concerned, [is] to be autonomous in the way you choose section 12 psychiatrists and that you choose the person who is best for the job, not who is dictated to you by somebody else. AMHP 15

Some participants alluded to an ‘informal’ rota within a Trust for independent/second opinion doctors.

In the absence of rotas, AMHPs would often have to try to find a s12 doctor, who was ‘on-call’, or else contact two independent s12 doctors:
They [= AMHPs] contact the psychiatric hospital that I work at, and they ask for the doctor ‘on-call’ and then the phone call goes through to me. S12 13

6.2.2. List of s12 doctors held by the local authority

The other main approach, as described by several AMHPs and participants from all groups was to go through a list of local s12 doctors, which was often held and updated by the local authority or the Trust. This list usually differentiated between Trust-employed doctors and independent doctors. In some places this list was only used for the second doctor/independent doctor:

[It’s a] local spreadsheet, some names provided by Trust, plus locally known doctors not employed by the Trust. AMHP 02

What we normally do is we just print out the list, put it in a folder so that when you’re looking to arrange to set up an assessment then we’re just looking at who I can ring. And then maybe if you’re struggling you can just go down the list. AMHP 16

6.2.3. S12 Solutions app

Other AMHPs found and contacted doctors via the S12 Solutions app, which we describe in detail in section ‘Technological resources’ as one development that has been tried to improve access. This seemed to be a main approach among seven AMHPs interviewed and was discussed by participants in all groups.

It was reported that typically, AMHPs would check for availability on the app, but then also call or text to confirm that availability:

So [on the S12 solution app] every section 12, as I understand it, they [AMHPs] just press a button and it comes up with a list of people that have declared themselves available, they look down the list to see who they know or who they want and then they ring you, so they still ring you in the traditional way or sometimes text you, so still via mobile phone. S12 03

6.2.4. ‘Privately’ held list of s12 doctors

As another approach, AMHPs used a ‘private’ list of s12 doctors, especially for the role of the second, independent doctor. This was mentioned by several AMHPs and also discussed by other participants.

An AMHP from a London Borough explained that there was not a lack of s12 doctors in London per se, but there were other problems securing them for assessments, such as a history of lack of helpfulness or inflexibility, so that they would only contact a small group of s12 doctors of which they were confident that they would attend, saving time on making unsuccessful phone calls:

I will always get a doctor, but, again, I think that that’s about personalities, in a way, unfortunately. I don’t agree with that, but I think there is an aspect of personality, you know. There are doctors that will say, ‘[name], ring me if you’re ever stuck,’ or whatever. Do you know what I mean? So, these are networks that have been built up over time. AMHP 04

However, other participants discussed the negative aspects of using only a small pool of doctors, which could mean that newly qualified doctors or Trainees were not called upon and other approved doctors felt excluded:
Lots of goodwill and support and response that we have from them, but equally it kind of shrinks down into using that pool and we lose the ability to know when we’ve got new, qualified section 12 doctors on their rotation or, you know, doing whatever part of their training. And I have the doctors feed back to me and say, ‘Well, I’m not going to keep updating my availability if I never get called,’ and so a lot of that is behaviour on behalf of the AMHPs that we need to challenge. AMHP 11

6.2.5. Finding and contacting doctors via a private, local WhatsApp group

Using a private, local contact list organised on WhatsApp was mentioned by several participants including an AMHP. Other participants also alluded to knowing of WhatsApp groups for s12 doctors, but acknowledged that AMHPs would not generally have access to the contact details contained in the groups:

They [AMHPs] can ring me directly or they can text, or there are a couple of WhatsApp groups locally. They can put like if it’s something short notice or maybe one that’s a bit remote maybe in the community, they would say is anyone available to help with this assessment, such and such a time in this place? They usually get a number of responses. S12 12

6.2.6. Additional approaches

There were additional approaches, mentioned by one or two participants:

- Working in a hospital as an AMHP, so having better access to in-house doctors
- Using an official local app to be launched in one area
- Contacting a crisis team.

A combination of several approaches, particularly for accessing second opinion s12 doctors, may be required, as typified by this s12 doctor participant:

For the second opinion doctor, the system, again is absolutely bizarre. So, in [London] some Boroughs, there is an informal list of mobile numbers that they know that are people who are known to do sections. And over time you slowly build up a relationship with individual AMHPs, so they know me, I know them, they know roughly what hours I work. S12 11

6.2.7. Assessments not organised by AMHPs

There are also some assessments that are not arranged by AMHPs, but by other professionals. Assessments may be arranged by administrative services, for example in a mental health hospital, where a hospital ward clerk often organises a second/independent doctor as well as contacting an AMHP:

[section] 2 and 3’s, mostly I would see at hospitals, they are booked through the ward clerk, and they arrange for the section 12 doctor, which has been going on for about three, four years now. [...] There are a couple of professional section 12 doctors and all they do is do that as a job, and they tend to have links into the hospital ward clerks who call them. So, we get a call to say, can you come and do a [section] 2 or a [section] 3 assessment and the two doctors are, and it’s all set up. AMHP 13
However, in many other cases AMHPs are needed to secure the involvement of a second opinion doctor:

*I think it’s getting hold of that second opinion doctor, is the difficult thing because you often have a psychiatrist who initiates the assessment and then the AMHP has to get hold of the second section 12 doctor and it’s that I think that causes some of the problems. So, they’re certainly part of it.* AMHP 02

Some assessments in A&E are also arranged by staff from the hospital, e.g., mental health nurses covering A&E, and they also call an AMHP when necessary.

### 6.2.8. Arranging MHA assessments under section 136

Experiences of assessments for s136 detentions also varied. A small number of participants from different groups reported that s12 doctors were available via a specific s136 rota system. This may reflect the increased urgency resulting from the Code of Practice (DH, 2015), which states that s136 assessments should commence within three hours of the person’s arrival at the place of safety and the 24-hour limit on s136 detentions. However, one AMHP reported that in a recent development there were greater problems in securing s12 doctors for s136 assessments:

*Potentially because of the unknown quantity that are there, they’re saying, you know, we don’t support Registrars going on their own to do the one-off assessments, whereas Consultants it would kind of be expected of them, but again, those Consultants that don’t do a lot of section 12 work have a lot of anxiety about it [s136 assessments]. So again, we’re getting this refusal to come out, either a non-availability or an actual refusal to come out to do the assessments.* AMHP 11

This led to a question about whether AMHPs should attend the place of safety when the involvement of two doctors had not been secured. Some AMHPs had been asked not to attend these assessments if there was no guarantee that two s12 doctors would attend.

### 6.3. Involvement of doctors who have previous acquaintance of the person

The MHA Code of Practice (DH, 2015: para 14.73) states that, where practicable, at least one of the doctors making a medical recommendation at an MHA assessment should have previous acquaintance with the person. The Code goes on to say: ‘It is preferable that a doctor who does not have previous acquaintance with the patient be approved under section 12 of the Act’ (DH, 2015: para 14.74).

### 6.3.1. Importance of involving a s12 doctor with prior acquaintance

Reflecting the views of many participants, the importance of having a professional who is known to the person being assessed was stressed by some members of the consultation group. They thought this could be particularly useful if the person is being assessed away from their home area. However, other members of the consultation group suggested that being detained on the recommendation of a psychiatrist who had been treating the person voluntarily could generate negative feelings from the patient and negatively affect the ongoing therapeutic relationship.

Many participants stressed the benefits of having a doctor with prior acquaintance of the patient at the assessment. When asked how they would arrange MHA assessments, several AMHPs emphasised that they would *always* try to contact the doctor treating the person (if known), or...
another doctor who had some previous acquaintance. Two AMHPs described local protocols or ‘algorithms’ to help ensure that a doctor with previous acquaintance was allocated to the AMHP:

In [region], they adopt this algorithm whereby there should be a process that’s followed prior to even coming to an AMHP ... to ensure that we’re following best practice in terms of the Code; it’s the doctor that knows them... I’m not going to say it’s 100% but, in essence, we should have that psychiatrist that worked with that individual. AMHP 04

One AMHP indicated that it was more likely for a person to be detained when no doctor with knowledge of the person attended the assessment. And one of the KI participants highlighted that doctors with previous acquaintance should attend assessments to improve care for the patient, and that they were urging AMHPs to ensure that these doctors were secured:

One of the things that we’re really pushing for our AMHPs to do is really go back to the teams where the person gets their care and just say, ‘Actually you’re the Psychiatrist, you’re the section 12 Psychiatrist in the team that’s working with this person, we need you to come out and be one of the doctors,’ so really driving that. NHS MGR 02

Furthermore, a small number of participants in the study from each professional group felt that it could be beneficial for at least one of the s12 doctors not to be previously acquainted with the patient. A person with no prior knowledge could bring a fresh perspective and vision to the assessment and not go back to previously made decisions. However, the importance of balancing the fresh perspective with the views of a doctor who knew the patient was emphasised:

With regard to previous acquaintance, if a patient is known, I think it needs to be one doctor that needs to have some familiarity with the patient. I think especially because when you’re dealing with certain patients that are particularly risky and ‘frequent flyers’, having that background awareness is important because it will change the outcome. The other part of me is thinking that sometimes conversely when you have people that are expecting patients to behave in a certain way because they’re so familiar, that can also have a negative. So, I think the balance of somebody, that if they’re an established patient and well known and very risky, having somebody that knows them and somebody that does not know them is a really nice mix to kind of give a good equal perspective. S12 19

Related to both psychiatrists or GPs with previous acquaintance attending assessments, three participants felt that the term ‘preferable’ instead of ‘mandatory’ in the Code of Practice was chosen to mask either general lack of and unavailability of s12 doctors or to allow doctors who had previous acquaintance to refuse attending assessments:

I’d like to say, the government’s done something very wrong in not insisting the doctors who know the patient is one of those people. [...] If you ask my stance, the only time they might say an independent doctor is better than a doctor that knows the person is if it’s going to be a really complex assessment around drugs and around personality disorder and mental disorder. [...] I suppose under those circumstances it is useful to have a strong section 12 doctor who’s going to stay focussed on the patient now, not the history from before. AMHP 01
6.3.2. Factors facilitating the involvement of s12 doctors with prior acquaintance

Several AMHPs and a s12 doctor said that this was less difficult with patients in the community who had previous history of assessments, although some participants pointed out that undertaking recurring assessments was not the same as involvement in treatment. Securing a s12 doctor with prior acquaintance was also felt to be less difficult for MHA assessments involving patients undergoing current hospital treatment, or where assessments were planned. This AMHP also made the point that treating psychiatrists would usually try to attend the assessment:

*I don’t think we have much of an issue of getting somebody that knows the person if they’re known to services. I mean obviously you’re going to have those that nobody knows but the general times or the older people, the people in mental health are known to a psychiatrist and there’s a general acceptance that they will put themselves out to come to the assessment.* AMHP 13

6.3.3. Barriers to involving a s12 doctor with prior acquaintance

Many AMHPs, NHS managers and KIs identified barriers to securing the involvement of a s12 doctor with prior acquaintance of the patient. They stated that this was often very difficult or even impossible for assessments:

- during s12 doctors’ normal hospital shifts, especially for assessments in the community,
- involving patients out of a Trust’s area,
- in A&E departments.

In addition, a small number of participants said that young psychiatrists often moved from Trust to Trust and are therefore not available for local assessments, where they might know patients. Finally, one AMHP reported that psychiatrists employed by private Mental Health care providers would refuse to attend assessments as it was not part of their contract:

*It’s often a real logistical problem getting a doctor who has previous acquaintance. We will often be able to get them, but they’ll have very strict boundaries about when they are available to do it and then you end up trying to orchestrate the whole assessment around one doctor’s availability which then actually, at the last minute, might change, so it can be a real frustration.* AMHP 05

6.4. Arranging MHA assessments without previous acquaintance

Several AMHPs explained that when doctors with previous knowledge were not available, they would try to find doctors with experience or specialist skills that could be beneficial for the person or could correspond with potential needs of the person in terms of gender and ethnicity:

*I do try and use other section 12 doctors that may assess the person in the past. If that’s not an option I will use section 12 doctors that I believe might be beneficial to that person’s sexual preference, race, position in society, although that’s quite hard.* AMHP 01

*My first thought is, ‘Who is the best person for the job? Who is the most appropriate?’ If it’s a child, can I get a child and adolescent section 12 psychiatrist? If it’s an older person, somebody who’s experienced in psychogeriatrics. So yeah, the first thought is, ‘who is the best for the job?’ The second thought is, ‘who is available?’* AMHP 15
Other AMHPs said that they would often have to revert to finding just any doctor who was available, diverting from the Code of Practice:

If you have the luxury of the time and you think about it, then yes, certainly my colleagues and I, we try and make a decision sometimes, who do we think is the best people to go about this, you know, the best AMHP, the best Doctor? But when you go back doing your (section) 36 referrals and five or six (section) 136s, you don’t have the luxury sometimes and it’s simply next one on the ramp. AMHP 03

Three AMHPs said that they would never try to find a doctor of previous acquaintance for emergency situations and for s136 assessments:

And, for example, we assess emergencies like at police stations, where we have to bring two doctors out, we immediately phone the section 12 doctors rather than trying to find their doctor or their GP. On the forms, we do write that this is an urgent assessment. It wouldn’t be practicable for us to try to wait for a doctor with previous acquaintance. AMHP 02

6.5. Involving GPs (with or without s12 approval)

When asked if they would ever involve doctors without s12 approval in MHA assessments, almost all participants referred to GPs as the only group of non-approved doctors that could potentially be involved. However, a majority of AMHPs and several other participants stated that it was almost impossible to involve a GP in MHA assessments, particularly GPs who were not s12 approved or had no further psychiatry background. Some AMHPs said that it was extremely rare for GPs to come out and it would cause frustration even trying, and many s12 doctors said that they never undertook an assessment with the GP of a person. As exceptions, one AMHP felt that sometimes a GP working in a more rural area might come out as they were more connected and invested in their community. A s12 doctor knew about rare occasions in London, and another AMHP said that as an ‘incredibly rare’ exception GPs with special commitment to a patient would be keen to undertake an assessment:

Asking GPs to attend, it’s just a non-starter. Most of our assessments are going to be done in surgery time, they are not going to make the time to come out unless they already have personally committed themselves to this patient. I’ve had one or two assessments where the GP says, ‘Oh no I will come, I’ve told you I will come.’ But that’s so rare, it’s almost not worth mentioning it, it’s so incredibly rare. AMHP 01

Another AMHP noted that the AMHP role in their area had changed and that they now worked in larger geographical areas, not knowing GPs personally anymore, and that they would thus rather choose to approach s12 doctors that they knew. This seemed to be widely the case as many participants said that it was standard practice that assessments were undertaken by two s12 approved doctors without previous acquaintance:

I think more or less, the vast proportion of Mental Health Act assessments are done by both doctors who are section 12 approved. NHS MGR 04

While one s12 doctor said that it was an advantage to have a GP involved as they could also physically assess a person, other participants said that most GPs were mostly not familiar with the process of MHA assessments or would lack psychiatric knowledge. As one participant noted:
I think it’s a good idea to have two section 12 approved doctors because they understand the situation rather than the patient’s GP altogether really. Obviously, it’s a great advantage to know the patient in the past but it’s also a great advantage to be section 12 with the experience, so you’re not going to get an idea and I’m not quite sure which is preferable, section 12 with no experience of the patient or experience of the patient and not be section 12. I’d say they’re pretty balanced. S12 01

However, one AMHP described working very closely with a s12 approved GP:

I’ve always heavily relied on a local GP who’s been around for many, many years and actually does great assessments. So yeah, he potentially knows a lot of the people that we work with, and he’s assessed them previously as well. But we don’t really have that many GPs, or if they show a level of interest and they then think, ‘Oh, I’ve got too much else going on’. AMHP 12

6.6. Definition of independence and conflict of interest in MHA assessments

The interpretation of the rules about what counts as independence in relation to s12 doctors undertaking MHA assessments varied. For example, different opinions were expressed about whether two s12 doctors working in the same Trust could be thought of as independent for the purposes of an MHA assessment. The size of the Trust and former relationships with Consultants and other s12 doctors were identified as factors influencing decisions about whether this would be acceptable. The position taken about independence also affected the balance of using s12 doctors doing assessments in their contracted time and independent s12 doctors. In addition, access to Trust systems and managing costs were cited as factors affecting policies and individual decisions about seeking, none, one or two independent s12 doctors in MHA assessments.

Most participants were aware of the change in regulation (The Mental Health (Conflicts of Interest) (England) Regulations 2008, reg. 6(1)(a)) that made it lawful for the two s12 doctors to be working for the same Trust as long as one did not have supervisory responsibility for the other and they were not working in the same team. Many of the KIs and CAPs felt that this approach was sufficient to ensure independence. Also, some s12 doctors indicated that they would not undertake an assessment as an independent doctor for the hospital in which they were working. Others felt that their employing Trust was so large that they would not know colleagues from other departments. However, no participant mentioned the Code of Practice point that it is good practice that the two doctors are not from the same Trust (DH, 2015: para 39.4).

Two Medical Directors provided a good illustration of contrasting practice. In one Trust area, according to the Medical Director, there were almost no s12 doctors who were not employed by the Trust, meaning that it was common that both doctors were from the same Trust and not infrequently in a line management relationship. In another, the participant asserted that they had never known both doctors at an assessment to have been employed by the same Trust, of which this participant was Medical Director.

In addition, several s12 doctors and AMHPs had reservations about whether doctors working at the same Trust could really work independently of each other, even if one was working on a fee-paying basis, outside their NHS duties. For example, several suggested there were inevitably some connections between all doctors working within a Trust. This was thought to be particularly likely where the two s12 doctors were at different levels of seniority, even if there was no current
management responsibility and it was felt that this could affect the judgement of a junior psychiatrist. One s12 doctor (who worked independently) explored both sides of the question:

As Trusts have got larger and larger, it became ridiculous. It was ridiculous really to say a consultant psychiatrist who worked in a completely different area of a Trust, say the whole of [the area], had got that conflict of interest with a doctor they didn’t know. But - and it’s a big but - because they’ve all trained in those Trusts, of course, they do know them, and they’ve worked for them in a junior capacity in training. S12 18

Other participants said that doctors should have a moral code to challenge other doctors in MHA assessments for the benefit of the patient – even if one was the Medical Director of the Trust:

The thing is that I am the Medical Director in the Trust, so I sort of professionally manage everyone. But if I think, I have to trust my colleagues to be able to disagree with me comfortably, even though I do line manage them. If we look at it, I mean, I wouldn’t be able to do any mental health work because I am the boss in that way. NHS MGR 04

However, one AMHP described a situation where a s12 doctor who had limited experience would be very unlikely to challenge the judgement of a trusted senior colleague:

I’ve actually heard, one of the AMHPs told me about an assessment saying, I think, with an ST5 and a consultant in liaison (psychiatry), saying, ‘Look, you know, she was once my mentor. You know, we’re not in a line manager responsibility now, so there’s no conflict of interest, but I’m telling you if she wants to give a med[ical] rec[ommendation], I’m giving one too, because I trust her.’ And it’s that kind of thing where you think that’s born out of relationships rather than seeing the situation objectively. AMHP 11

A small number of participants said that they had experienced Trust doctors working together in almost fraudulent ways. For example, one AMHP reported that a s12 doctor had told another doctor to provide their home address instead of their work address on the related paperwork to obscure that they were working in a line-management relationship, while another AMHP felt that doctors would suggest working with certain other doctors to secure work for financial benefit.

One Medical Director said that it was their Trust’s firm policy, in agreement with the AMHP service, to ensure the first recommendation came from a Trust doctor (on a dedicated s12 rota) because that doctor would be better informed about bed availability and alternatives to admission. Further, two KIs stated that the ideal situation would be one Trust doctor and one external doctor from outside the Trust to ensure high quality assessments:

I suppose the ideal situation is to have one of our doctors doing the Mental Health Act assessment along with another doctor who is external, and actually, I think that’s quite good. That provides some challenges: less cosy, less, you know, decide something with your immediate work colleagues and people you know. You have to sign it with somebody who’s a bit more objective. NHS MGR 05

In addition, one NHS manager expressed a belief that two external s12 doctors would be more likely to recommend compulsory hospital admission, which created a pressure on beds:
They haven't got any ongoing connections, contacts, resources, knowledge of resources to find reasonable alternatives and I think the direction was more ... really trying to manage the threshold for admission and really trying to manage the beds carefully. It's not ideal having two external section 12 doctors. So, we really try and avoid that where we can. NHS MGR 05

Managing costs was given by several KIs as a reason for trying to limit the number of independent s12 doctors doing MHA assessments for a fee:

The real driver was trying to limit the cost, the ever-increasing cost of the section 12 budget ... it's just a massive cost pressure, unfunded. NHS MGR 03

However, access to external or independent doctors was not always easy and several AMHPs said that they could only involve a very small number of completely independent s12 doctors to ensure that they would not break the rules around conflict of interest when arranging MHA assessments. Having limited access to independent doctors was one difficulty highlighted by participants leading to delays in MHA assessments, which are now explored in more detail in the next chapter.
Chapter 7 Reasons for delays in arranging MHA assessments and main difficulties

7.1. Introduction
This chapter reports the different reasons offered by participants for delays in MHA assessments, in order to place the importance of difficulties in involving s12 doctors in context. When asked for the main reasons for delays in MHA assessments to take place, three reasons were given by most participants:

- lack of availability of doctors/s12 doctors
- lack of availability of AMHPs
- lack of availability of (mental health) beds.

These reasons will be explored in detail in the chapter, along with a range of other factors identified as potentially causing delays.

While most participants said that there were delays to assessments, the regional chairs, a small number of AMHPs, s12 doctors and KIs emphasised that delays did not happen on a regular basis and tended to occur only for exceptional reasons, such as need for specialist involvement or out of hour assessments:

I think the process goes well in about 78% of the time. So, there are some hiccups in delays here sometimes. The majority of the cases, usually you have good effort in arranging and conducting the assessment within a few hours of it being requested. CAP 02

Furthermore, two AMHPs pointed out that AMHPs were not part of the emergency services and that MHA assessments should not be deemed an emergency service with absolute availability for both AMHPs and s12 doctors:

AMHPs are not in team 999, I don’t have blue lights or faster stripes on my car, because sometimes AMHPs are expected to step into this space. And you know there isn’t a readily available array of doctors. [...] It works because everybody is frightened of what’s going to happen next, particularly if you don’t get it done. AMHP 03

7.2. Lack of availability of doctors/s12 doctors
Many participants, from all professional backgrounds, felt that there was a lack of s12 doctors or that there were great difficulties in securing them to undertake MHA assessments. In contrast, a small number of AMHPs reported that in general they had never experienced any difficulties in securing doctors for a MHA assessment, though one had only been conducting assessments for six months. For example, one AMHP stressed the availability of s12 doctors as a cause of delays, but reported feeling blamed for delays that were out their control:

[The hospital] had raised an incident report because the AMHP hadn’t come within four hours and I just felt so disheartened kind of thinking I’m trying and this is not my fault, you guys don’t have a doctor, if I come by myself, there’s no point, I won’t be able to do anything, so it’s mainly doctors. AMHP 10
Several participants expressed that while theoretically there might be sufficient s12 doctors approved and/or known to CCGs and Trusts, in reality there were not enough s12 doctors making themselves available for MHA assessments. We explore s12 doctors’ motivations for making themselves available for MHA assessments and reason not to do so in Chapter 4:

_We have a dichotomy there. The CCG aren’t managing the contracting. They are saying, ‘We’re providing sufficient section 12 doctors.’ The [NHS] Trusts are equally saying, ‘We’ve got sufficient section 12 doctors.’ But then why am I having to ring 20 doctors to finally get one to come out? Yeah, we’ve got lots, but they’re not all performing Mental Health Act assessments._ AMHP 04

Several AMHPs linked the difficulties in accessing s12 doctors with the fact that undertaking MHA assessments is not a contractual duty for all s12 doctors, especially outside of working hours:

_It’s accountability. I think. As AMHPs, there’s an expectation that you will respond to every Mental Health Act assessment. With section 12 doctors, that’s not a statutory duty in quite the same way and therefore, we’re reliant on goodwill._ AMHP 04

_The consultants are very clear that it’s not part of their contractual responsibilities to be available for Mental Health Act assessments when they’re ‘on-call’, you know, which is reasonable if they’ve got jobs to go to during working hours as well._ AMHP 07

As discussed above, several local areas relied on completely independent doctors for a second opinion or to take part in MHA assessments. Several participants from all professional groups felt that, in their areas, including London Boroughs, there was a lack of these doctors and that they relied on a small number of doctors working completely independently and not employed by an NHS Trust. However, a small number of other participants felt that the shortage of s12 doctors was systemic and related to general staff shortages in health and social care, coupled with what was felt to be a lack of strategic approach to working planning in relation to s12 doctors:

_It’s a workforce issue. There’s no strategic workforce issue planning about the requirement to have a sufficient number of section 12 approved doctors._ NHS MGR 06

### 7.2.1. Access to doctors or s12 doctors with specialist knowledge

Many participants identified accessing doctors/s12 doctors with sub-specialisms for MHA assessments as causing delays, although only two participants identified this as a main cause of delays. In addition, some participants also reported planned delays to allow a better qualified team of doctors to be present, for example instead of using doctors from an out of hours emergency shift. In contrast, other participants felt that they had appropriate knowledge as to what was needed to carry out assessments with patients with special needs, including learning disabilities or autism and children and adolescents, due to their training:

_Not really, I mean because we have a generic on-call rota, so we cover everyone. I mean we used to have separate rotas but about four years back we went to a generic rota, and we search on-call or if you’re section 12, you will cover everyone._ Children, old age, working age, everyone, learning disability, everyone. NHS MGR 04
Almost all AMHPs and many other participants said that it was difficult to secure specialists for children’s assessments, others also mentioned problems securing doctors with ‘geriatric’ sub-specialism. However, one KI said that in the experience of AMHPs in their area, these teams were more responsive than general Community Mental Health Teams:

I think, particularly Community Mental Health Teams, they’re so busy that it’s really difficult for them to create that space to be able to be part of that assessment. I’ve been talking to the AMHPs, and they say to me that specialist teams like CAMHS, older adults, early intervention, they’re much more responsive and will provide a section 12 doctor to come out. NHS MGR 02

Children and adolescents
Difficulties in accessing s12 doctors with experience of working with children and adolescents were most commonly reported:

I mean one thing to say is that we have very poor availability of CAMHS doctors. The only appointment time that we can find that we can get CAMHS doctors is on weekend or after kind of 6-7 o'clock in the evening. So, we do find that we’ll have a young person, say, brought in on a Statutory 136, taken to our local children’s hospital or a place of safety in the morning and we can’t get a CAMHS doctor to come out and conduct an assessment with us until about 6-7 o’clock in the evening. AMHP 07

While one s12 participant pointed out that they would undertake assessments with children or adolescents as part of their ‘on-call’ duty, others said that they would not feel confident doing so:

Our on-call also means we have to cover CAMHS. So, I did do six months in CAMHS 25 years ago. And the process for admitting people to a child bed, out of hours, is very, very difficult, bureaucratic; and really it should be that there are specialists involved, you know, the implications of locking anyone up, which is kind of what the power is, you know, it should be more consequential for a child, so I think actually having appropriate advice from people who are specialist in areas, you’ve got to be able to manage systems and you haven’t always got enough numbers. S12 10

However, a small number of participants had not experienced any difficulties securing appropriate CAMHS doctors, which they attributed to a centralised approach to referral management:

Because we have a sort of centralised component around referral management, it means that there’s a lot more knowledge in the team. So, it means that getting CAMHS doctors-- And we’ve worked quite hard down the years to bring CAMHS doctors up to speed on what might be required. Because the referrals of children are going up, and have been steadily, you know, we used to make one [assessment] once a month, now we’re kind of like one a week, sometimes two, three a week. So, needing the CAMHS speciality has become a little bit easier for us. AMHP 06

Learning disabilities or autism
With regard to learning disabilities (LD) or autism two participants felt that there were greater barriers due to a lack of available doctors with that sub-specialism:
For me, it’s just maybe sometimes when you need a specialism, especially learning difficulties is quite hard because I think we’ve only got two LD specialists. AMHP 12

It should also be highlighted that several AMHPs said that assessments of people with learning disabilities were extremely rare, especially unplanned ones:

Learning disability, I would say not so much and the reason for that is that you get a learning disability assessment and it’s very rare that that assessment is just for that day. Learning disability assessments roll on for weeks. So, therefore, it gives you that extra opportunity to plan and to ensure that you’ve got the right people attending. AMHP 15

When specifically asked about access to specialists with a learning disability or autism background, several participants from all professional groups thought that there were no problems. Two s12 doctors pointed out that there was a learning disabilities consultant on-call 24/7 in their areas to draw upon if there were any questions. Also, some reported sufficient doctors were available: this was made more likely because most assessments involving people with learning disabilities were planned in advance, as noted above, making it easier for doctors to attend:

We’re very good, I think, up here with learning disabilities and autism. And the specialist doctors involved they make themselves very available. So, we always have one for any assessment. AMHP 13

Many other participants felt that doctors with specialist knowledge should be involved in such MHA assessments, and this appeared to be possible. Indeed, some s12 doctors were reluctant to be involved in such assessments, because they feel they had not got the right expertise:

There are certain presentations that doctors are more likely to turn down. So, for example if I was asked to do an assessment, if I wasn’t on-call, if it wasn’t part of my contractual duty, and I was asked to do an assessment for a learning difficulty patient, I would say, ‘No,’ because I don’t feel that I’ve got the right expertise or competency. S12 19

Other potential needs and challenges
One AMHP and one s12 participant reported a general lack of female s12 doctors which created a problem in some situations when involving female s12 doctors might be preferable:

I mean we have a complete lack of female section 12s. A few weeks ago, there is myself, the person we were assessing who was female, and I had two female section 12s. And at the end of it I just said, ‘This is amazing,’ you know, because it so rarely happens, so rarely happens. But for us they are specific that, you know, women with past issues of trauma from males and that can be tricky. AMHP 12

Some challenges were reported in involving doctors from minority ethnic groups in assessments, especially Black/Black-Caribbean doctors, but also doctors of Asian ethnicity. This fits with our analysis of the Approvals Register (see Chapter 3: Analysis of the Approvals Register). Some participants felt that this was not so much the case in cities such as London or Birmingham:
I work in a big city, multi-racial, multi-cultural, and psychiatry as a speciality, I think is very reliant on overseas Doctors who’ve come here. So, we have Doctors who have very good community language skills. AMHP 03

But other participants pointed towards the lack of UK doctors with minority ethnicity backgrounds among the general medical workforce in some areas and felt that this also applied to London.

With regard to languages, when asked, several participants indicated that they would either try to involve a s12 doctor who could speak a certain language via existing channels, for example the S12 Solutions app or based on knowledge in the team. Some noted that it was much more common to rely on telephone interpreters, who were often accessed via the translation agency ‘LanguageLine’, which might give rise to delays. However, some members of our consultation group emphasised the importance of having known people to translate for the person being assessed.

One AMHP mentioned that having doctors with sub-specialism in substance abuse involved in assessments would help them arrange for the most appropriate team to undertake MHA assessments where substance abuse was part of the problem.

7.2.2. Covid-19 pandemic
A small number of participants described how the Covid-19 pandemic had made it more difficult to access s12 doctors. Some NHS s12 on-call doctors were working from home and others (mainly independent s12 doctors) chose not to make themselves available, either to protect themselves or others, and were therefore unable to undertake assessments:

The issue through the pandemic I think has been the so-called independent section 12 doctors. So, a lot of them, it’s not just financial, a lot of them have chosen that role because it works around childcare arrangements and so on. And, of course, all of those with young children at the start of the pandemic said, ‘We don’t want to go into Covid areas.’ So, they stopped working almost entirely. CAP 03

7.3. Lack of availability of AMHPs
Lack of AMHPs’ availability to attend MHA assessments was also discussed as one of the main reasons that could be leading to delays, mainly by s12 doctors but also by participants from other professional backgrounds, including a small number of AMHPs.

Some participants clearly felt that there were too few AMHPs:

It feels much more like air traffic control than it does healthcare to be honest. So, we’re obviously constantly prioritising and so generally we can get a team together at relatively short notice. The problem comes, say like a day like today, where we have got, I think it was, 27 AMHP requests on the board, we don’t have 27 AMHPs. AMHP 06

This theme was specified more particularly by several participants who thought that AMHPs were too busy, especially when working ‘out of hours’ when they tend to work generically (such as on general emergency duty teams). As a result, their responsibilities were so broad that they could not always provide an AMHP service. For example, other responsibilities, such as urgent child safeguarding, could take precedence over MHA assessments:
Definitely out of hours the AMHPs’ workload and seeming to, you know, (have) responsibility for a huge number of different things. As I mentioned, child safeguarding and other things that will just take priority. s12 03

One s12 doctor argued that AMHPs’ central role in organising MHA assessments meant that delays caused by AMHPs’ availability were not considered sufficiently. They also felt that a broader view was needed to be taken about reducing delays in MHA assessments, including the overall level of resources in health and social care. This latter point was echoed by other participants:

The AMHPs say they’ve got problems but obviously what you are not looking at is the problems with AMHPs. So, they’re controlling a system. There are Mental Health Act assessments that get delayed because there’s no AMHPs and no-one looks at that because no-one’s asking, the AMHPs are controlling the system, so it’s kind of done on their terms. So, I don’t think it’s just about section 12 doctors, I think you’ve got to look at the whole system and ask whether there’s enough investment [in general]. S12 10

One s12 doctor felt that some AMHPs would decide not to attend a patient and then blame a lack of s12 doctors:

I think some of it is also the AMHP not wanting to come out at stupid AM [hours] and kind of just saying, ‘Oh, well, there wasn’t a section 12 doctor’. Not to throw all my AMHP colleagues under the bus [laughs], but that’s also happened at times. S12 04

7.4. Difficulties securing (mental health) hospital beds

The third main reason leading to delays in conducting MHA assessments, identified by many participants from all backgrounds, was a lack of (mental health) beds being available at short notice. In addition to delaying the outcome of MHA assessment (such as hospital admission), a small number of participants reported that some MHA assessments were postponed because beds were not available:

I think it’s really important to raise [that] there aren’t enough beds in the country, let alone in the places that we work. So sometimes the assessments, I do think they’re appropriately, in certain instances, delayed because there’s no point going out causing a situation that is potentially inflammatory, doing an assessment when you then can’t place the patient anywhere. S12 19

There were also reports by several participants that in some areas AMHPs would refuse to attend an assessment before a bed was secured, which caused concern for this Panel Chair:

It depends within the region, where you are, you will have some areas of the region that AMHPs will refuse to go out to do an assessment until a bed’s been identified and there are issues around bed availability. We keep advising them that’s unlawful, because trying to predicate that the assessment will say somebody needs to come in, they really shouldn’t be doing that. CAP 01

Several participants also highlighted the different approaches as to how a bed was secured in different areas of the country. The MHA Code of Practice (DH, 2015: para 14.77) states that the doctor is responsible for securing a bed if a decision is made to admit compulsorily. However, many AMHPs reported that they took on that responsibility in reality, echoing the findings of our previous
study (Stevens et al., 2019). It was unclear whether this was by an official arrangement between Trusts/CCGs and local authorities (this was not mentioned but would be possible) or had become an accepted ongoing practice. This independent s12 doctor explained that they would not feel responsible for securing a bed:

*In theory it’s the doctor’s responsibility to find a bed, but I never feel responsible being a section 12 non-psychiatrist to do that. Generally, the social worker or AMHP, [...] it is said, it’s not their responsibility to find a bed, but they’re usually the person that accepts that role. They’re the people that do all the work, hanging about after [the assessment].* S12 01

Only one s12 doctor reported taking responsibility for checking the availability of beds:

*What I generally do is before I go out and do a Mental Health Act assessment, I phone our gatekeepers to see what the bed situation is and if it sounds like it’s someone that’s very unwell and will need a bed, or well-known and usually would come in, then if there isn’t a bed locally, then I ask them to start looking for an out-of-area bed for me. I’m yet to need an out-of-area bed, normally, at that point, they’ve shuffled round the wards and manage to make a bed somewhere in our hospital.* S12 13

Other participants reported that AMHPs should work closely with Trust bed managers to organise beds. While some participants reported problems collaborating with bed managers, others felt that in their area appropriate systems were in place:

*I’ve seen no evidence that’s [finding beds] delaying things at the moment, because the bed finding has to sit with the Bed Management Team and they just have to get on to them and they just have to sort it somehow.* NHS MGR 05

### 7.5. Other difficulties in securing s12 doctors’ involvement in MHA assessments

Difficulties securing doctors/s12 doctors’ involvement at certain times, geographical variations, and access to doctors with certain sub-specialisms were all identified by participants. Many participants from all backgrounds acknowledged that a combination of these factors would cause further delays.

#### 7.5.1. Relationships between doctors and AMHPs during the assessment process

We asked about the working relationships between AMHPs and s12 doctors, as this had arisen as a potential concern in previous research, which may affect the ease with which AMHPs can secure the involvement of s12 doctors. The vast majority of AMHPs and s12 doctors described working relationships between professionals from the other group in general as ‘good, fine, brilliant, positive’. Several AMHPs and s12 doctors highlighted that they felt supported in their responsibilities by professionals from the other group and that they were working in partnership rather than in an adversarial relationship. This view was echoed by Panel Chairs and KIs, one of whom called the relationship ‘constructive’. Many reported that they felt that in general, relationships were positive and that differences of opinion could be overcome through discussion and by having the best for the patient in mind:

*I think the working relationship’s generally very good. I mean it’s a very positive relationship, I think generally there’s a relationship of mutual respect and people work together very effectively. [...] On assessments I think it’s extremely rare to*
have a problem. I think if there are differences of opinions they tend to be worked through effectively and professionally. KI 02

However, one AMHP described their relationship with s12 doctors as ‘mixed’, and another had experienced ‘adversarial’ relationships when working in a previous area. Also, some participants indicated that there could be general tensions, especially around a perceived unfairness regarding differences in how doctors and AMHPs were remunerated for undertaking assessments, but that these rarely impacted on collaboration during an assessment:

I think the bigger challenge or the bigger tension that there is, is that doctors get paid probably more for Mental Health (Act) assessments than the AMHPs get paid every day. I think that’s a big tension. And there is no requirement for doctors to write anything up, sometimes it’s zero, they literally walk away without others. KI 01

Also, some AMHPs thought that their work was not appreciated and recognised by doctors or organisationally:

I don’t think AMHPs get the credit for – it’s not about me, it’s about AMHPs in general – I don’t think they get the credit. [...] But what I tend to see, and it’s happened recently is, when the AMHP disagrees and the Doctor’s unhappy, then they sort of stamp their feet and it sort of escalates. [...] And that goes back to the sort of NHS being a big beast too, I think AMHPs sometimes are put under a huge amount of pressure by a system and doctors to do as they are required, do as they want them to do. AMHP 03

However, several s12 doctors and NHS MGRs highlighted the value of professional tensions between doctors and AMHPs as they would sometimes follow very different models and had different roles and responsibilities in an assessment that needed to be brought together for each person. Indeed, it was felt that mutual learning and understanding could follow from this tension:

I really like to work with them [AMHPs] because they come to the assessment from the social work perspective [...] I like seeing patients from the social work perspective, I think often they bring with someone thinking about the social work perspective, I think sometimes they bring an important focus on the social element of the illness like accommodation, benefits and other things too. [...] Its probably quite healthy -, a break from the Doctor having too much authority in the scenario. S12 08

Concerns were raised by two AMHPs about the quality of medical assessments. One AMHP pointed out that medical recommendations written by doctors sometimes lacked the necessary information on the degree and nature of presentation or the capacity of a person to enable a successful assessment. Another felt that the quality of an assessment would greatly improve for the patient, but also themself, if doctors would prepare for an assessment by thoroughly reading the documentation for the patient and investing appropriate time during the assessment to ask questions based on the medical notes and to take time to discuss any decisions made. As we describe above and below, several independent s12 doctors reported that they did not have access to medical notes, which would make this preparation difficult.

However, several KIs noted that potential tensions were not caused by the immediate relationship and collaboration of AMHPs and doctors in the assessment but were more systemic:
I think there are challenges when there is a lack of capacity in either availability of section 12 workforce or AMHP workforce. So, there’s a number of escalations that happen due to that, but I think that tension is much more of a managerial one rather than implementation when you are seeing a patient. NHS MGR 06

7.5.2. Facilitators and barriers for successful relationships and assessments
Participants identified facilitators and barriers to good working relationships: a small number focused on each of the following:

**Facilitators**
- Being able to choose to work with specific colleagues, with whom they had good relationships and/or shared professional views
- Co-location of AMHPs and doctors
- Regular combined work meetings between professionals working across several Trusts and local authorities

**Barriers to successful relationships and assessments**
- Uncertainty of roles and responsibilities especially about the power of the AMHP in the assessment and in securing beds
- Poor relationships between Trusts and local authorities
- A lack of integration between Trusts and local authorities
- Poor punctuality of s12 doctors and AMHPs
- Conflicting assessment styles and approaches

7.5.3. Decision-making and implementation of decisions
There was potential for conflict when the three assessors do not agree on the right decision for the person whether to detain or not to detain and when AMHPs decide to go against two recommendations to detain (under the MHA, AMHPs cannot detain if both doctors recommend against detention). This potential challenge was mentioned by several participants from different backgrounds, however, most participants discussing this topic felt that these situations were rare and that decisions were usually reached by consensus:

*I mean the vast majority of cases either we all agree, or if there is a disagreement it’s possible to have a reasonable discussion and agree. It’s very, very rare that we don’t eventually reach a consensus. I mean off the top of my head I can think of about three in ten years. S12 17*

Several participants from different professional groups acknowledged that it was sometimes difficult to find the right balance between taking someone’s liberty away and the risk that this person might pose to themselves and others:

*I was going to say that where you have two doctors that have made recommendations and the AMHP decides not to make the application, I think there needs to be a difficult conversation. Not necessarily unpleasant but difficult conversation because it’s all about risk management and risk taking then and how to manage that. I think by and large people are able to get through that and come to an agreement on how to manage that risk and how to continue to oversee it. KI 02*
Though conflicts were rare, several AMHPs reported situations where they had felt that the doctors wanted to force them to agree with a detention when they did not feel that this was the right decision. They also felt that it was important for them as AMHPs to stand by their decision:

*I mean I've been in positions where the Doctor have said to me, 'If this person kills somebody, or kills themselves, that'll be your fault,' that's quite uncomfortable. And as a younger AMHP or an ASW (Approved Social Worker – the precursor to the AMHP) you're kind of going, 'Oh?' you know. As a more experienced AMHP, my response would be, 'Well that's not a very professional thing to say dear doctor, is it?'* AMHP 03

One of the possible compromises, as argued by several participants, was to use the 14 days of discretion before patients have to be admitted to hospital (DH, 2015: para 14.87) in order to review the situation before a final decision is made:

*We do the assessment, they give their recommendation, we have a discussion how we think we're going to proceed and stuff. So, for example, a couple of times that I didn't make an application. I had the mental recommendations, but I thought we can use [least restrictive] option, so I used my 14-days discretion, so I removed the crisis team.* AMHP 02

Some AMHPs questioned whether some s12 doctors took sufficient time to discuss a patient’s situation when making their recommendation. Several AMHPs reported feeling being left on their own when communicating a decision to detain to the person being since the doctors would leave immediately after the clinical assessment and decision. This was in addition to being left to secure a bed (as described above). For example, this AMHP identified a tendency for some s12 doctors to leave quickly, while stressing that this did not reflect the behaviour of all s12 doctors:

*Some doctors will instantly walk out and say, ‘Just give me the paperwork,’ without having a discussion and you do have to try to talk to them [...] I think there is a feeling for some doctors that they just want to move on to the next [assessment] rather than actually investing in that patient at the time. But some doctors are great, and some doctors will really talk about this, will help afterwards to call specific hospitals if needed, bed management, things like that, but probably less often than we would like.* AMHP 10

In contrast, three AMHPs said that they felt very well supported by doctors to communicate and implement any outcomes of an assessment and how the doctor would stay, for example, until a bed was secured:

*As to how the decision is communicated to the patient, I’m quite impressed, we have identified that doctors do want to come back and that they don’t necessarily just leave that to the AMHP, because sometimes it’s also quite difficult as well, you know, we aren’t able to communicate a decision because, we’ve completed the assessment interview but we can’t tell the patient that they’re detained under the Mental Health Act because there isn’t a bed to admit them to at that point. So that’s often a difficulty in communicating that decision as well.* AMHP 07
7.5.4. Time of day

There was a curious balance between participants reporting that it was either easier or more difficult to secure a s12 doctor, especially from NHS Trusts, for assessments during working time hours (9am to 5pm) compared to after 5pm. The analysis of the Approvals Register indicated that numbers of s12 doctors making themselves available for MHA assessments increased a little between 5pm and 9pm. Night-time assessments seemed to be a problem everywhere, which fits our analysis of the Approvals Register, which showed that availability was lowest overnight (see Chapter 3: Analysis of the Approvals Register).

Several AMHPs and KIs said that it was not a problem to secure s12 doctors from an NHS Trust during working time hours. This was partly because there were more Trust doctors but also independent doctors willing to attend:

We’re very lucky in terms of those people that are employed by [NHS Foundation Trust], they do manage their diary to come out and do the independent section 12 work in their own time during working days, because I know in other areas that’s an issue that a lot of assessments get pushed to out of hours because the doctors’ clinics are too fully booked and they don’t have capacity to come out in the middle of the day. AMHP 11

One consequence of this was that it became difficult to access s12 doctors after 5pm as one AMHP put it:

I think a lot of the times problems we have is when the assessment might be around five or six o’clock in the evening, they [= doctors] want to go home. AMHP 11

In direct contrast to these experiences, a high number of participants reported difficulties surrounding securing a s12 doctor for MHA assessments during working hours. They felt that doctors were already too engaged in other assessments or treatments during their shifts and were thus often unwilling or unable to attend assessments in the community. They also felt that this applied to doctors in hospitals and in Community Mental Health Teams. One AMHP felt that it was also difficult to arrange an assessment with independent doctors around school drop-off and pick-up times. Another stressed that the difficulty became more pronounced later in the day:

Generally speaking, the earlier in the day the easier it is [to secure a s12 doctor], the busier the day, the harder it gets. AMHP 06

Several participants stated that it became easier to access s12 doctors in the evening until about midnight. This fits well with the pattern of availability we found in the analysis of the Approvals Register (see Chapter 3: Analysis of the Approvals Register). Some of these participants from different professional backgrounds said that it was unsurprising that some s12 doctors would become available after 5pm as their normal shifts working for an NHS Trust would end and they could start working ‘independently’ for a fee, thus the additional income being an incentive making them more willing to attend:

Another thing is, in this Trust, quite an important distinction, in the daytime the Trust doctors don’t receive the money, that goes to the Trust. Out of hours, as soon as the clock ticks past 5[pm] they get the money, and so we could argue that that’s a bit of a motivator for getting people out. AMHP 06
There was much agreement that the most difficult time to secure hospital based or independent s12 doctors (or other doctors for that matter) to attend MHA assessments was from 10pm or 12am onwards. Again, this accords well with the analysis of the Approvals Register (see Chapter 3: Analysis of the Approvals Register). Almost all participants reported experiencing difficulties accessing s12 doctors in this period. For several of these participants, this was also the main difficulty. It was also said, by two s12 doctors, that s136 assessments were particularly affected by delays due to unavailability of s12 doctors in the late night/early morning period. For example, some participants highlighted that having to work in their ‘normal’ post in the morning made working night shifts really difficult as they would be sleep deprived, which could make it hard to start their day jobs on time and not rested enough to attend other treatments:

> It’s quite difficult from that time until the following day because doctors don’t really like doing early morning assessments because they’ve got another job to go onto, so a couple of times when I’ve persuaded people to come out with me to do an assessment say at six o’clock in the morning, it’s taken them so long that they’ve actually been late for their daytime job. So, lots of them aren’t very happy to do that. KI 03

Bank holiday or school holidays also limited access to s12 doctors as two AMHPs, one NHS manager and one s12 doctor said that they were sometimes called upon as a back-up on weekends.

### 7.5.5. Location

A rural location was described as the main reason for delays by a small number of participants from all professional backgrounds, especially if this involved lengthy and difficult travel conditions:

> We’re sort of 45 minutes on a good day from the nearest motorway junction, so that’s always going to be a little bit tricky for us and, of course, because we’re a holiday place, then during the holiday season, you could double that time. So, then you have to factor that into somebody’s travelling time. So, a section 12 doctor based in [city], it could, on a hot, sunny day in July, take him three hours to get here. So, you know, you can understand the reluctance to do that. AMHP 09

### 7.6. Other reasons for delays

A small number of participants also identified other reasons for delays:

- Police services not attending
- Warrants not being issued
- Ambulance not available
- Reasons within the patient/service user, for example intoxication
- Not enough access to patient’s medical history
Chapter 8 Approaches to improving the availability of s12 doctors at MHA assessments

8.1. Introduction
This Chapter focuses on existing resources and initiatives which bear on s12 doctor availability. In particular, we asked participants about their experience (if any) of the Approvals Register and of the S12 Solutions app. Also included here are participant accounts of local initiatives aimed at improving the availability of s12 doctors.

8.2. Approvals Register
The Approvals Register, held by the Department of Health and Social Care (see our analysis of data held on the Approvals Register in Chapter 3), is one resource for identifying s12 approved doctors available to AMHPs. Separate parts of the Approvals Register are administered and held in different regions. We asked participants whether they were aware of the Approvals Register and, if so, whether it was useful in facilitating MHA assessments.

8.2.1. Awareness of the Approvals Register
We found that the Register was less well known among our participants compared to the S12 Solutions app. While 47 participants across our sample knew about the app, 39 were aware of the Approvals Register (all the Trust managers were familiar with the Approvals Register).

8.2.2. Use of the Approvals Register
A very small number of participants reported using the Approvals Register to find s12 doctors for assessments; a few others spoke about using it to verify the status of s12 doctors.

Finding doctors
Among our AMHP participants, the Approvals Register was rarely used to find s12 doctors – most of these professionals either preferring their own lists, which they had developed over time, or use of the S12 Solutions app. The key drawback of the Approvals Register, according to several AMHPs, was that it did not tell you whether the doctor concerned was available for assessments on a particular day. Two AMHPs pointed out that the Approvals Register was not a good guide to the availability of s12 doctors to undertake MHA assessments beyond their own workloads:

[Just] because they’re on the database [Approvals Register], but they’ve got no intention ever of dealing with Mental Health Act assessments outside of their own caseloads. AMHP 04

It’s all very well thinking, ‘Oh this person sounds perfect,’ but then they can’t come out because they’re on holiday, well the database [Approvals Register] isn’t going to tell you that. AMHP 14

The same participant pointed out that this information was what the S12 Solutions app provided.

However, two AMHPs provided an exception to this picture. One reported having used the Approvals Register to search for doctors in a neighbouring area when they had been unable to find one closer to hand. Along similar lines, another said they relied on the Approvals Register when organising an assessment out-of-area.
Verifying approval status

An Approvals Panel Chair said that finding s12 doctors for assessments was not the purpose of the Approvals Register, but it could be used to verify status:

*The database [Approvals Register] is there primarily to record who is approved as opposed to being much more accessible to the end user in relation to, I want a section 12 doctor who is fluent in Urdu, who is a learning disability specialist, I mean that’s what you want to be able to tap in and find out who is available within your region, but it doesn’t do that.* CAP 01

This interview was one of two where we heard that there had been instances of compulsory admissions being recommended by a doctor whose approval under s12 was not current, rendering the detentions illegal. As a result, the Approvals Panel in the area concerned had promoted use of the Approvals Register among AMHPs for verification purposes. In the other case, following an illegal detention of this kind (in a different area), the administrator at the AMHP service had regularly checked the Approvals Register to ensure that the s12 doctors on AMHP lists were approved. That said, a small number of participants argued forcefully that it was not the AMHP’s role to ensure that the doctor had current s12 approval:

*I don’t think it’s the AMHP’s responsibility to confirm section 12 – they’re confirming that themselves on their medical recommendation that they are section 12 approved.* AMHP 04

*I think it’s reasonable to expect those section 12 doctors to take the professional responsibility for their own approval. If they represent themselves to us, as section 12 approved, I think it’s reasonable that we could actually be able to rely on that.* KI 03

Several participants, including the AMHP lead where there had been an illegal detention, pointed out that the S12 Solutions app only listed approved doctors, although the app also relies on doctors to maintain their approval on the Approvals Register to ensure it has up-to-date information on doctors’ approval status. The app was being introduced in this area, meaning that the administrator at the service no longer had to perform this checking task.

8.3. S12 Solutions app

As noted above, almost all (n=47) our participants knew about of the existence of the S12 Solutions app. Here we report participant views about the advantages and disadvantages of the app. We also note possible barriers to take-up or effective use of the app and potential improvements to the app suggested in interviews. In an interview, Amy Manning (the S12 Solutions app founder, who worked as an AMHP at the time) described her motivation for setting up the S12 Solutions app in 2017 as having been rooted in her frustrations about the means available to find information to help her make contact with s12 doctors:

*I just remember having a really terrible shift, somebody was having an awful time in their place of safety, and I had my paper list, and I couldn’t find a doctor to come out. And then I had to get the next city along fax me their list, and I couldn’t find anyone, and I spent hours ringing doctors. [...] and I sat there with the paper list and thought, well this is the tool, the tool I’m given to do my job and it’s not good enough, it’s not supportive [...] I’m letting this person down, this person’s having a terrible time, I’m letting them down, it didn’t make me feel I was doing my job.* KI 01

8.3.1. Advantages of the S12 Solutions app

Three main advantages of the app were described by participants: information about the availability of s12 doctors; facilitating the payment of fees; and supporting the smooth running of MHA
assessments. Within each of these we have ordered the perceived positive aspects of the app according to how many of our participants raised the point.

**The app shows doctor availability**

This was the advantage highlighted by the largest number of participants. Several AMHPs, including one senior one, valued the fact that it enabled them to identify doctors’ availability quickly, which was also noted as a point of distinction with the Approvals Register (see above). In addition, this benefit reduced administrative work for administrators and doctors:

*It’s just a much more organised process, I suppose. You know, prior to that we would drop an email to all the medics in the organisation on a Friday saying, ‘Can you give us availability for the week upcoming?’, and we would have a whiteboard with when doctors were available at certain points during the week. And that has, you know, streamlined the work so much for our administrator that she no longer has to work full time. You know, we’ve managed to sort of reduce down her hours. She wanted to as well, obviously, but, you know, it took away a large part of the work that that administrator was doing so, […] it’s definitely made things easier.*

AMHP 11

Doctors also reported that it lessened the chance of being called by AMHPs when they were not working:

*Hopefully I get fewer unnecessary calls because they can see your availability, so if you’re going on holiday, you can block the week and you shouldn’t be getting called about that week at all.* S12 08

Finding s12 doctors for MHA assessments taking place out of AMHPs’ areas was stressed as an advantage of the app by a small number of them:

*It’s the simple fact that, it possibly simplifies getting me a doctor because I do a fair bit of out-of-area work and I wouldn’t know the local doctors, so it’s made that more straightforward for me.* AMHP 03

Along similar lines, one of the AMHPs had learnt via the app of s12 doctors who lived and (usually) worked on the other side of the county border, and now was using them, particularly when out of hours assessments presented difficulties in finding a doctor.

Another consequence of having information about availability was the ability to broaden the range of doctors that they knew about, which was specifically highlighted as a benefit by a small number of participants:

*I think the app has been a good start because it has really extended the pool of doctors that we know, you know names are now popping up that we’ve never heard of before and we are kind of just thinking, ‘let’s give it a go’. AMHP 10*

The app was also felt to be helpful in finding specialist doctors, mentioned by a small number of AMHPs and KIs. For example, one AMHP had found the app useful when needing a forensic doctor and another noted its usefulness in finding s12 doctors with language skills (KI 02). A third AMHP felt the app was useful in finding s12 doctors with a wide range of specialties:

*I think particularly for the niche areas it’s really helpful, so things like perinatal, autism, learning disabilities, CAMHS, particularly eating disorders, those are the two particularly that are really helpful.* AMHP 14
Fee payment is made quicker, simpler and more reliable by the app

We heard from several s12 doctors and some others that the app made fee payment for independent s12 work quicker. For example, one s12 doctor noted that some areas had previously been paying fees three months after the assessments, which the S12 Solutions app had improved:

*I’m paid every two weeks by Section 12 Solutions right up to about the day before as well. So, it’s perfect at the moment. S12 01*

The app was also reported to have a positive impact on the bureaucracy involved in making fee claims. We identified two aspects to this. First was the ability to move away from paper forms. A senior Trust manager at the pilot stage of the app’s implementation reported that their Trust’s Mental Health Act Office staff were very keen on this aspect:

*Improving or getting rid of the bureaucracy around pay forms, those paper forms that go backwards and forwards, I think we’re really hoping that will improve things. NHS MGR 02*

Second, the app was reported by some to afford greater transparency around payment, which helped s12 doctors making claims to identify which patients were involved and to distinguish assessments which were eligible for a fee from those that had been undertaken during NHS-paid shifts:

*They’re able to go back and see, you know, rather than jotting down on pieces of paper the NHS numbers of the patients that they’ve seen, they’re able to log in and see that on the apps themselves. We’re also able to go in and sort of make sure that those things have been claimed properly – that there’s no errors. AMHP 11*

In connection with this, one AMHP speculated in relation to an app developed by the local CCG (so, not the S12 Solutions app) that part of the CCG’s motivation for the initiative had been to inhibit ‘double-charging’, thereby saving the CCG money. By double-charging they were referring to doctors who reportedly claim a fee for an assessment that was already formally part of their paid work.

Improves coordination of MHA assessments

Many participants felt that the S12 Solutions app helped in coordinating MHA assessments in other ways. First was that having electronic records, rather than paper forms increased the security and confidentiality of patient details during the preparation for and after the MHA assessments because of the way that forms were passed around prior to the introduction of the app:

*It [the form] had to go through about three hands. The forms were transferred from one place to another with a lot of patient details on them. So – confidential aspect. S12 01*

In addition, one s12 doctor highlighted that enabling the use of electronic forms helped lessen the workload on AMHPs. This also had a potential positive knock-on effect on the speed of passing on information about the outcomes of MHA assessments and on professional relationships:

*I’ve heard from AMHPs as well, it’s a lot nicer than them having to carry round paper forms and those paper forms sometimes never reaching where they need to, sometimes reaching there and then not getting processed. So, electronically I think there’s huge benefits. Just saving time, making relationships a little bit easier, not having awkward conversations about forms. S12 19*
Workflow and resource allocation

Two AMHPs reflected that the app enabled AMHPs to collaborate and share tasks more effectively:

I have no problems, I mean first of all it’s relatively simple to use, I think one of most helpful features is that you can kind of access the whole team for assessments and so you know my colleague can find the doctors for me and set it up, I can then create the claims. AMHP 10

One participant described how, as AMHP lead, they had oversight of team resource allocation and the app helped them to co-ordinate work accordingly:

I guess the other advantage of using that versus the database [Approvals Register] is when I was lead AMHP I was able to see who my colleagues had rung in terms of the assessments they were trying to do and who they’d lined up so that was quite useful. So, for example, I think doing out of hours one day I was able to see that my colleague, I was going to the same hospital as a colleague and so was able to use the doctors that he had lined up straight after him and it enables you to see what time the assessments are lined up so you know, you know if you are lead AMHP you know when to be saying to people ‘ok, can you give us an update please?’ AMHP 14

One s12 doctor saw improved resource allocation as a benefit for Trusts:

It enables Trusts to see what’s happening but more importantly, it enables you to allocate resources in time and geography much, much more efficiently. S12 18

S12 Solutions are responsive

Finally, one AMHP remarked that the company behind the app had been comparatively prompt in responding to reported problems:

Yeah, so I’m happy with it and I think they’ve been very – you know, where we’ve encountered common problems, the section 12 app guys are really responsive in terms of making changes. Whereas you know sometimes say at [City] Council systems you can identify a problem and it can take years to kind of work through that problem, whereas the section 12 app guys are kind of on it. They recognise the problem and within a short time you’ll get the email to say, ‘Please note we’ve made these changes to the app based on responses to us.’ AMHP 15

8.3.2. Drawbacks of the app

Technical issues

A small number of participants reported technical problems with the app, although it was not clear to them whether it was a problem with the app or with their phone. For example, one AMHP service manager disparaged a version change in the app:

The current version is a bit clunky in that you have to start by setting the assessment up first and then from that, search for the doctors. Whereas, the old app, you started with looking for the doctors first. So, I […] want to know which doctors are available right now rather than have to start typing in patient details to search for doctors. AMHP 07

The app is internet dependent

One AMHP pointed out that where there was no internet, it was not then possible to access doctors’ phone numbers.
**Doctors not updating the app**
While not a comment on the app’s capability itself, two AMHPs had found the main difficulty using the app arose when doctors did not update their availability on it.

**Negative effect on practice?**
One KI speculated that the ease of finding available s12 doctors could have a negative impact on how hard AMHPs try to find a doctor with previous acquaintance:

> I suppose there’s a risk [that you] don’t look for somebody that knows the person well. There is that risk that if it becomes too easy just to find doctors from, you know, independent doctors who don’t know the person then there’s the risk of not, er, doing, working hard enough to get somebody who knows the person. That’s the risk, that’s not a problem with the app, that’s a problem with how people respond. KI 02

**A private enterprise**
One Medical Director would have preferred the app to be administered directly by the CCG, or in any case by a public body, ‘with accountability, statutory responsibilities, monitoring and oversight by NHS England Improvement, CQC’ (NHS MGR 07). We asked participants whether an app run by DHSC would be supported by them and there was broad agreement with the idea. But it was also pointed out by some that with the S12 Solutions app, there was now no need for then DHSC to develop its own app.

**8.3.3. Potential barriers to take-up or effective use of the app**

**Discomfort with new technology**
A small number of AMHPs and s12 doctors said that technological innovation itself was a barrier. One AMHP described herself as ‘a bit of a luddite’, for example. A s12 doctor said: ‘I’m not very technically friendly and I’m not very tech savvy. So, I might let AMHPs have my phone number and they can ring me.’ (S12 20). Others speculated that, although it might seem ageist to say it (given the age profile of this workforce), AMHPs may not be an easy group to persuade to take up the app. In order to overcome resistance to change, one Trust had arranged that doctors could only be paid via the app.

**Reluctance to depart from existing lists**
Possibly overlapping with a discomfort with new technology was the reported phenomenon of AMHPs preferring to stay with their list of known s12 doctors. One AMHP lead in an area where the app had recently been introduced described this as AMHPs ‘reverting to type’ (AMHP 11). Newly signed-up doctors on the app complained that they did not see the point of updating their availability if they were never called:

> As I say, AMHPs are creatures of habit, and they like, you know, they’ll probably continue to work with the people they know unless someone isn’t available and then they might, I guess, have a look on the app to see whether there’s anyone vacant. S12 04

The AMHP lead referred to above suggested that, in their area, this reluctance to make the shift meant that the app was only being used to process claims rather than find doctors in the first place, adding that it was ‘a very expensive claims system if we’re not going to use it correctly’ (AMHP 11).

**Cost**
The findings on cost from these interviews are not strong. Typically, participants were not aware of the cost of the app or which organisation bore responsibility to pay for it. Personal correspondence from Amy Manning, S12 Solutions app founder, explained their approach to the calculation of costs:
The cost for S12 Solutions is calculated using the number of local authorities within the local footprint; it may also be influenced by population size and the number of AMHP teams. The distribution of the cost among local authority, mental health trust and clinical commissioning group organisations within the local footprint varies across the country. Amy Manning, correspondence

Where participants had experience of the app and were aware of who paid for it, this was most often being done by the CCG. In one case where the Trust rather than the CCG was going to pay as the app was being shortly introduced, the senior manager interviewed expected the cost to be shared with the local authority (NHS MGR 02).

A few participants expressed some concern about cost. Some argued that the app was not necessary in any case, given they did not see a problem around s12 doctor availability. Others, though, noted that the cost of the app was likely outweighed by administrative savings.

8.3.4. Potential improvements to the app
We asked participants whether they had any ideas of ways that the app could be improved. Three suggestions were made.

- **Appraisal function**
  One key informant suggested that it should be possible for the app to allow AMHPs to appraise s12 doctors’ work, particularly where they were non-Trust doctors. This would be a means of improving governance of this group.

- **Include referral notes**
  One s12 doctor said it would be useful if more information about the referral could be included in the app so that they would not be coming to the assessment ‘knowing nothing’ (S12 08).

- **Bed and transport availability**
  There was speculation whether the app could helpfully be extended to helping with the coordination of these two aspects of the compulsory admission process.

8.4. Local initiatives
We asked participants whether they knew of any local approaches aimed at improving the availability of s12 doctors and, if so, whether these had been evaluated. We were told of a few arrangements and initiatives. However, none had been formally evaluated.

8.4.1. Use of rotas
Many participants described approaches to setting up rotas to ensure the availability of Trust s12 doctors to undertake MHA assessments during their salaried time, which were believed to be very useful by AMHPs, s12 doctors, KIs and CAPs. One senior Trust manager said that two things that had helped in improving doctor availability were an on-call rota of junior doctors and an out of hours GP service that included a s12 rota. Typically, Trusts had rotas for their employed psychiatrists to be first opinion s12 doctors. One s12 doctor described how a typical rota, for first opinion s12 doctors, worked in their area:

> So, there’s a rota, so you have a day which you do section 12 duty and then you’re asked to go out and see anyone who requires a section 12 doctor if you can. I mean obviously sometimes there might be two simultaneously and you can’t be at two cases at once. But basically, you’re free ... So, then you’ll probably see several that day and because I don’t do that much clinical work. S12 07
They acknowledged that this did not bring any more money to the doctor concerned but noted:

*And it’s interesting, cos it’s one of the few times when I think everyone agrees. Even though all it did was increase the work that the doctors all had to do, it didn’t take away anything. It increased it for no remuneration. I think everybody agrees it’s better.* S12 07

There were different approaches to managing rotas, although no strong views about which was the best. First, there were differences in coverage of daytime and out of hours. Some had separate rotas for s136 MHA assessments and community or hospital-initiated assessments. In other areas, s12 doctors were expected to be available for MHA assessments as part of the normal on-call shifts, when they were also responsible for in-patient duties, which one NHS manager acknowledged could make the on-call shift ‘really busy’ (NHS MGR 04).

In one area the Trust had also tried to have a rota of Trust doctors to be second opinion s12 doctors as part of their NHS work (not being able to claim a fee), although they had not been able to staff this sufficiently:

*The reality is, that has not worked really, it’s been very, very difficult to get doctors, consultants to sign up to that in a way that’s compatible with their day-to-day work. So now we’re very much reliant on the local AMHPs finding an independent doctor.* NHS MGR 03

Rotas for second opinion independent s12 doctors were far less common. In one example, a CCG maintained a rota of GPs or other s12 approved doctors working outside the NHS who were willing to make themselves available for fee-paying MHA assessments. The Mental Health Trust from which the CCG commissioned services also maintained a rota of hospital psychiatrists willing to do s136 MHA assessments in places of safety, again on a fee-paying basis. This had proved problematic because of differentials in pay: the CCG paid the non-psychiatrists for being on its rota, whereas the Trust did not.

One NHS manager outlined the importance of maintaining a fine balance in running rotas for s12 doctors, to ensure they were properly staffed, without affecting the availability of doctors for non-urgent work, some of which could reduce the need for MHA assessments. They stressed the importance of job planning and the overall numbers of doctors in order to run a rota:

*I actually think with job planning you are able to do a rota, however you need to have sufficient numbers of people to be able to cover a rota effectively without non-urgent work suffering. Because that’s it, isn’t it, the problem being is if you move all your consultants to a section 12 rota, whether that’s a 24/7 rota or just a daytime rota as we could have on-call out of hours, but that means there’s a loss of work in the daytime, of elective work and prevention and stopping people requiring a section 12 doctor.* NHS MGR 06

Another s12 doctor reported the use of an informal rota set up between doctors and AMHP managers in the face of difficulties in finding doctors out of hours:

*So, the Trust are sort of aware of it, but they do not want to touch it in any sense. It’s mutually beneficial for everyone, but I think the Trust are just trying to stay out of it. In other (local authorities), which is the majority, apart from [area] where this kind of rota situation is going, it’s basically a free-for-all.* S12 04
One option for improvement, as suggested by a s12 doctor, was to develop multiple-Trust rota arrangements for out of hours work. This proposal had been mooted at their Trust, which serves a rural area. By being able to call on many more doctors this would involve them in a low frequency rota (perhaps a 1 in 30), but problems were foreseen around increased intensity when on-call, with assessments potentially involving long journeys for the professionals concerned. It was not clear to this participant whether the plan was to go ahead. Another aspect of this proposal had been that doctors would be entitled to a day’s leave following their s12 on-call, an arrangement that was reported as being in place in another area by one of the Medical Director participants.

8.4.2. Difficulties with rotas

In one Trust a participant reported that it had been difficult to ensure that the in-hours (9am to 5pm) rota for s12 work was filled. In addition, the Trust was finding it very difficult to ensure that one of the doctors making recommendations at out of hours assessments was Trust-employed without encroaching on junior doctors’ rest hours. As a result of this, the Medical Director at this Trust said that they were trialling a system arranged with their local out-of-hours AMHP service (the Emergency Duty Team – EDT) in which, between midnight and 5am, both doctors could be independent.

Two other difficulties with rotas were raised by some participants. The first concerned the changeover time. One Trust manager reported that where an assessment was being called mid-afternoon, Trust doctors could see that by the time they reached the place of assessment it would be past the end of their working day and as a result they were refusing to do it, causing extended waiting times. A Medical Director described a comparable scenario in which the crisis team might arrive for an assessment at 4pm but the section could not be arranged until 6pm whereupon the daytime AMHP and doctors went home leaving the case in the hands of the EDT. However, the EDT had been known to refuse to take the case on, claiming that it was the daytime AMHP’s responsibility, meaning that the patient had to wait until the next day for assessment.

The second was reported by two non-Trust s12 doctors. They described how the arrangement by the Trust with the AMHP service, here that the first medical recommendation would come from a Trust employee, meant that sometimes assessments would have to wait if the Trust doctor was not immediately available. In their view, this caused longer time scales on occasion, which were not necessary given the availability of non-Trust doctors such as themselves.

Staffing s12 rotas of each kind appeared to be problematic for the following reasons. These were reported mainly by KIs, but corroborated by some AMHPs:

- Unpredictability of demand
- Where the Trust covered large geographical areas
- Ensuring the s12 doctors were released from clinical duties
- The general shortage of consultants
- Increased pressure on s12 doctors in smaller Trusts, who would need to be on the rota more frequently than their counterparts in large Trusts
- Staffing out of hours (particularly between 00:00 and 05:00) was more difficult because of the requirement for on-call doctors to be able to get at least five uninterrupted hours sleep
8.4.3. Use of other apps and digital tools
In one area it was reported by a s12 doctor and an AMHP that the CCG was rolling out its own app designed to facilitate the finding of s12 doctors for MHA assessments. This was in its early stages, and while there were reportedly ‘teething problems’ with the initiative, it was thought by the doctor that it would help AMHPs, especially in finding the second doctor for assessments.

Participants from several areas reported the positive impact of using WhatsApp groups. Described by one independent s12 doctor as ‘a start to actually planning resources far more efficiently’ (S12 18), the chief benefit was that it obviated the need for AMHPs to call around several doctors. Instead, doctors on the app could respond to messages from AMHPs with their availability. However, it did not have the locator or payment component of the S12 Solutions app, and in one area a s12 doctor noted that activity on the WhatsApp group had declined markedly, leading them to speculate whether there had been a move onto the S12 Solutions app.

8.4.4. Goodwill initiatives
Two AMHPs reported their attempts to encourage Trust doctors to put themselves forward for MHA assessment work. One had asked the Medical Director to send out an email supporting the attempt but had heard nothing back. The other, who was aware of the high proportion of s12 doctors at their Trust not doing MHA assessments in the community, described a pilot project they had proposed to undertake that involved making overtures to the group:

...pursuing them essentially to say, you know, ‘Come on. Come and get some experience. Come and meet us.’ You know, ‘I promise you, you’ll enjoy this, we’ve got really good group of AMHPs that are very skilled, very experienced, give you a lot of confidence.’ You know, ‘It’s, it’s a great way. […] when you get to know someone and they’re like, ‘Oh, well, I’m moving house.’ ‘Well, here’s a great way of earning some extra money. Come and do some section 12 work with us, it’ll be great.’ AMHP 11

One Medical Director, who described local s12 doctor availability as a serious concern, noted that while there was a one in 20 rota for the work, it was not a contractual requirement for staff to sign up. They were not aware of any initiatives to counter the problem but said:

I mean what I usually do is that when I go to the medical staff committee, I will just try to sort of ask them very nicely, that they should make themselves available and just use their goodwill. But there’s only so much that you can use people’s goodwill.

NHS MGR 04

8.4.5. Out-of-area doctors
In one rural area we were told of a recent initiative which involved calling on s12 doctors in neighbouring areas, but ‘geographically, we were just too far. They were very pleasant and very nice, you know, but they were just too far out for those people to come’ (AMHP 09).

8.4.6. Data collection
As we noted at the start of this chapter, none of the initiatives described here had been evaluated, except the S12 Solutions app. Indeed, for the most part, participants were not aware of any data collection on waiting times in relation to MHA assessments. One manager reported their Trust’s Mental Health Act Office was compiling a quarterly submission. While this recorded various data, for example when both doctors at an assessment were external to the Trust, data collection did not include waiting times.
An exception to this picture was reported by a senior Trust manager who said that the AMHP service collected delay data, recording whether the wait was due to the availability of the police or of a s12 doctor, or whether the lack of a bed was a factor here. Both this manager and a colleague saw the piloting of the S12 Solutions app as an opportunity to learn about waiting times and to improve the Trust response to the need for assessments.
Chapter 9 Possible changes that may improve doctor availability

9.1. Introduction

This chapter reports the views of participants on possible future changes that may improve availability. We enquired if they considered the imposition of a statutory obligation on Trusts to ensure that there are sufficient s12 doctors would be a good idea. We also asked for their views about the mooted introduction of a waiting time standard for MHA assessments. Finally, we asked participants about their own thoughts on what might improve the availability situation (assuming they perceived a problem).

9.2. Should a statutory obligation be placed on the NHS to ensure that sufficient s12 doctors are available to carry out their roles under the MHA?

The nature of MHA assessment work means that the workload at any given time is unpredictable. As one AMHP put it, ‘we can have days when we have absolutely no assessments across the whole county and then the next day, we will have ten, it’s just the nature of the work’ (AMHP 05). Even so, according to the MHA Code of Practice, local authorities are ‘responsible for ensuring that sufficient AMHPs are available to carry out their roles under the Act’ (DH, 2015: para 14.35), although no criteria are given to judge what might be a ‘sufficient’ number. The Code states that ‘local authorities should have arrangements in place in their area to provide a 24-hour service that can respond to patients’ needs’ (DH, 2015: para 14.35). These obligations are grounded in s13 MHA 1983, which states that, in cases possibly requiring compulsory admission, local authorities ‘shall make arrangements for an approved mental health professional to consider the patient’s case on their behalf.’ However, there are no equivalent obligations placed on the NHS to ensure there are sufficient s12 doctors and to make sure there are arrangements in place to provide a 24-hour service. We asked whether such equivalent obligations should be introduced.

9.2.1. A ‘mirror duty’

There was broad consensus across all participant groups in favour of such a move. One KI argued that there should be what they called a ‘mirror duty’ (KI 02) placed on the NHS to that contained in s13 MHA 1983. While such a position was widely supported, few participants stated that they thought this because of a shortage of s12 doctors. Rather, participants often expressed the view that the problem lay in doctors’ lack of willingness to do MHA assessments out of hours. Hence, the ‘arrangements’ that would need to be made in fulfilling such a mirror duty revolved around contractual terms and optimised rotas, rather than recruitment or encouragement to become s12 approved. For example, one AMHP service lead reflected that in their area there were enough s12 doctors, all of them registered on the S12 Solutions app, but not enough were available to do MHA assessments:

But they’re not making themselves available for assessments. So, you have that many technically available, but they’re not prepared to do the work or they’re not making themselves available to work or they’re not updating the app. AMHP 11

They estimated that AMHPs used only about a fifth of the s12 doctors at the Trust, because the others were not making themselves available, with five of them being called up at least two or three times a week. As we found in our analysis of the Approvals Register (see Chapter 3), only about a third of s12 doctors had indicated they would make themselves available for MHA assessments on a fee-paying basis. Another AMHP described the problem being that the work was voluntary – ‘it’s an add-on, it’s an extra you get paid for’ (AMHP 03). Some participants argued it was not enough for Trusts to say they had a certain number of s12 doctors between the hours of 9am-5pm. The nature of MHA assessment work meant that availability had to be arranged at all hours. As one manager of an EDT service put it:
I think there needs to be a legal responsibility on CCGs and Trusts to provide sufficient section 12 doctors, with a range of skills on a 24/7 basis – there is no legal requirement to do that at the moment. KI 03

One AMHP described a local policy which stated that AMHPs should conduct a minimum number of MHA assessments per year, suggesting that a similar approach could be taken with s12 doctors, as a condition of approval. Another AMHP argued that placing an obligation on CCGs in relation to the availability of s12 doctors would prompt the organisational restructuring that was required to meet the need. Making sure that undertaking MHA assessments was seen as part of a s12 doctor’s job was proposed by a KI and one s12 doctor as one way to increase availability:

I think that’s a reasonable thing to ask. I mean like in our Trust it’s regarded as part of your job, and I think it should be regarded as part of everyone’s job. You know, our job, there are things that people enjoy doing more or less, but our job is actually about serving the patient and their family. S12 07

Finally, we heard a variety of opinions as to which body should bear such a responsibility, were a duty to be introduced, with some saying it should be Trusts, others the CCGs, and one Medical Director saying it should be the new local Integrated Care System. This reflects the concerns about organisational responsibility for MHA assessments, discussed in Chapter 5.

9.2.2. Reservations expressed about introducing a duty
There were two caveats to this general support for the idea of a duty to be placed on the NHS with respect to s12 doctor availability. One s12 doctor queried whether instituting such a legal obligation would lead to an obligation to do out of hours s12 work:

The other question is, do you then start making folk like me do section 12 assessments and no, I think the answer to that is no, I don’t think that we should be adding to what folk have to do all day. S12 06

Along similar lines, one Medical Director was opposed to the idea of the extra obligation on the grounds that at their Trust out of hours s12 work was not part of doctors’ contracts and so the Director was unable to ‘enforce’ availability (NHS MGR 04). On the other hand, we found evidence of variation here: a Medical Director in a different area reported that out of hours s12 work was part of the doctors’ core contract in their Trust (NHS MGR 08).

9.3. Should there be a waiting time standard for the commencement of an MHA assessment?
One of the recommendations of The Independent Review of the Mental Health Act 1983 (DHSC, 2018) was that the Government should consider introducing a waiting time standard for the commencement of an MHA assessment following a referral. It was left unclear as to exactly how this might operate. The White Paper (Secretary of State for Health and Social Care and the Lord Chancellor and Secretary of State for Justice, 2021) indicated an intention to carry out sector engagement on potential new standards during 2021/22. While sympathetic to the goal of wanting to reduce waiting times, participants were predominantly opposed to the suggestion of introducing targets in this area.

9.3.1. Parity of esteem
As noted below, most participants were supportive of reducing waiting times, but they predominantly came down against the idea of a standard. Where respondents were in support of a
standard, they sometimes approached the question from the point of view that the notion of parity of esteem between physical and mental illness argues in favour of a prompt response, which a target would reinforce:

[...]

One AMHP who supported the introduction of a standard pointed out that legally the second medical recommendation could come up to five days after the first one, rendering the assessment itself into a very protracted affair. Another AMHP reported that in their area the service worked to a three-hour time standard between referral and MHA assessment. Another who was in favour of a standard said:

Yeah, it would be helpful and, and then if we're not meeting it, an exploration as to why. AMHP 08

9.3.2. Reasons participants opposed a waiting time standard

Clinical circumstances

The main reason participants were opposed to the idea was because clinical circumstances might call for delay after a referral had been made. One KI thought the idea of a waiting time standard would not take account of the widely varying circumstances in this kind of work, all of which could influence the time taken to complete an MHA assessment:

I think it is undeniable that there should not be undue delay in starting assessment which needs to start soon. I think it’s simplistic to just measure the time from assessment, from referral to when the assessment takes place because it can be a whole host of reasons why an assessment might not take place for one day, two days, three days or a week. And it could be due to very reasonable and adequate and appropriate clinical reasons. KI 02

Delaying an MHA assessment, was described by two AMHPs as sometimes being a deliberate choice, based on the needs of the patient and context of the MHA assessment. Also, a KI pointed out, a proposed waiting time standard between referral and commencement of an MHA assessment might potentially curtail endeavours to find a less restrictive response to the individual’s mental ill health. One member of the consultation group felt that a waiting time standard might lead to rushed and more disturbing assessments, supporting the need for a more flexible approach being described by some research participants. Echoing this view, one AMHP described how extra time was sometimes needed to allow for in-depth investigation, which could involve gathering the views of a wide range of professionals and family members, for example:

You get that ability to really dig in and do a lot more, investigation and seeking information about this individual that’s had the referral made about them. So sometimes you need that time to make contact with all those relevant people, prior to doing an assessment because sometimes you might find out something that makes it totally inappropriate to go. You know, it’s not unusual for a referral to come through from professionals all hollering and shouting, saying, ‘This person needs to
be detained,’ and actually nobody’s spoken to the family or the next of kin or, you know, their husband, wife, child, whoever they live with and they’re saying, ‘No, I don’t want my loved one to go into hospital. I’m happy to manage this with some help and support at home.’ And I think it’s those kinds of things that need to be explored fully and there’s no timeframe that you can set around that. You know, I still think it’s such a significant decision that you shouldn’t have a timeframe on that.

AMHP 11

Other AMHPs and some s12 doctors expressed similar serious reservations about the proposal. Doctors reflected that it might be necessary to delay an assessment because the individual was intoxicated. Allowing someone to sleep might enable the person to engage in the assessment in a more meaningful way. Another s12 doctor spoke of the value in seeming inefficiencies:

I think some of the inefficiencies arise from the good parts of it like wanting you to be seen by independent doctors and so, I would be loathed to make it, you know, in quotation marks, easier to detain people at the expense of all the independence benefits. Some of the time delay can be beneficial because by the time, a few hours have passed, a patient may present a bit differently, they may have rested, if they’ve been intoxicated, that would have worn off. Of course, you shouldn’t see someone if they’re not fit to be seen but it’s not always great to be seen twice in two hours, it might be overwhelming, or your presentation might change. So, I suppose I would just say efficiency is not always what you want, sometimes a bit of give in the system is no bad thing. S12 08

Unintended consequences

While basically sympathetic to the idea of reducing waiting times, several participants referred to the distorting effects of the four-hour standard for Accident and Emergency (A&E) as an ominous precedent here. These participants acknowledged that it was obviously objectionable to have people in a mental health crisis waiting for a MHA assessment, but one doctor did ‘fear what would happen if that came in in real life, we both know that there would be an absolutely crazy level of gerrymandering, with all sorts of crazy pathways built up’ (S12 11). A Medical Director, who was on the point of retirement, said that the proposal sounded ‘self-evidently immediately a good idea’ but was concerned about the ‘unintended consequences’ of such a move:

My experience of waiting time standards is, they become distorting factors and they don’t necessarily answer the question you want, you know, so you know, you can just imagine the neglect that could happen to other places where we need AMHPs and section 12 assessments, like on the wards or CTO (Community Treatment Order) reviews or preventative work or whatever, they become the only thing that we’ve got to tick a box to because we’re going to get reported on and put on the naughty step if we don’t do it. Do I sound like a medical manager by any chance? NHS MGR 03

However, a comparison was made by a CAP with the reduced time limits in relation to s136 MHA assessments (since 2017) and how this had driven change and improved the experience of patients and carers by prompting professionals to change their practice. But others pointed out that these time limits referred to actual periods of (short-term) detention under the Act, rather than the time it took to arrange an MHA assessment:

Somebody who’s already contained and captured, in inverted commas, that’s good to put a timescale on that, that is useful, but not just for any old referral. AMHP 06

However, a comparison was made by a CAP with the reduced time limits in relation to s136 MHA assessments (since 2017) and how this had driven change and improved the experience of patients and carers by prompting professionals to change their practice. But others pointed out that these time limits referred to actual periods of (short-term) detention under the Act, rather than the time it took to arrange an MHA assessment:
On the other hand, one s12 doctor suggested that the target would itself be a driver for recruiting more s12 doctors.

**Focus on waiting times for beds, rather than assessments**

Another response to our question here was that the standard would measure the wrong thing and that the main concern was around bed shortages. A Trust senior manager suggested that it was more important to institute a waiting time standard on the time between the decision to make an application for compulsory admission and the provision of a bed. They suggested that four hours should be the ‘absolute limit’ for this (NHS MGR 05). We heard from one Medical Director (NHS MGR 06) that four hours was the waiting time standard used in their Trust between assessment and finding a bed. This participant agreed with others that instituting a standard between referral and commencement did not sit well with the nature of the decision making involved in MHA assessments.

**Other objections**

Additional objections were raised by a small number of participants:

- A standard might be difficult to meet in some rural areas because of the distances involved.
- A properly resourced health and social care system, with sufficient s12 doctors and AMHPs would be needed to meet a waiting time standard.

### 9.4. Participant suggestions of changes that might improve s12 doctor availability

We asked participants for their views on what legislative or organisational changes might help in reducing MHA assessment waiting times. The most common legislative change they focused on was the introduction of a duty on Trusts that mirrored the statutory obligation placed on local authorities by s13 MHA, as we report above. Here, we give an account of other changes suggested by participants (where they saw a problem) that might improve s12 doctor availability.

#### 9.4.1. Improved liaison between doctors and AMHPs

A small number of participants stressed the importance of better liaison between doctors and AMHPs, which would improve relationships and help manage operational matters on a day-to-day basis:

> I think it would be a good idea to more formalise meetings between AMHPs and their reps and [the] Trust [...] It’s good practice because you are working with them, often in tense situations, so that’s often... sometimes it’s best not to meet them for the first time in that situation, it’s nice to know the people you are working with but also to iron out any problems. I mean some AMHPs are brilliant and they will scan Mental Health Act papers to make sure the doctors have written everything they need to write so you haven’t said anything about community treatments, whatever, but some AMHPs seem to not do that at all and we get some, you know, stuff that just has to be bounced back to the doctor, so there’s several things that I think a more mature conversation in the light of day rather than at the time of the assessment would be perhaps good. NHS MGR 01

One senior Trust manager recounted how, during the COVID-19 pandemic, they had set up virtual meetings with the AMHP managers, initially weekly, then on a monthly basis. They described daily bed management meetings that AMHP managers attended as making a ‘massive difference’ because of the danger otherwise of misunderstandings growing up between professionals as to where the strains in the system lay (NHS MGR 02). The existence of these meetings was more important, in
their view, than questions of integration: the AMHP manager from one of the local authorities that had recently pulled out of an integration arrangement was still coming to these virtual meetings.

A s12 doctor discussed the value of similar virtual meetings that had started during the pandemic – they described them as part-clinical, part-operational and considered that an ongoing regular interface involving AMHPs might be helpful to facilitating MHA assessments.

One CAP noted the value such regular meetings might have on ensuring that poor AMHP availability was not the reason for a delayed MHA assessment. They said better communications could be used to make AMHPs aware, in timely fashion, that a patient was likely to require moving from a s2 to a s3 detention (rather than this being left to the last minute, as the expiry of the s2 approached).

9.4.2. Who can do s12 work?
Two participants questioned whether the pool of available s12 doctors might be enlarged. This might be done by lowering the approval criteria. One CAP suggested this as one way to enable more GPs and surgeons to become s12 approved. Another KI suggested there was an ‘untapped resource’ among doctors, particularly GPs.
Chapter 10 Discussion and Conclusion
This study has provided insights into the factors affecting AMHPs’ reported difficulties in accessing s12 approved doctors to undertake MHA assessments, going back over two decades (Greenberg et al., 2002). Such difficulties have been identified as important factors leading to delays in assessments, with all the consequent impacts on people being assessed (ADASS and NHS Benchmarking, 2018).

We examined this question from a broad perspective, exploring the views of s12 doctors, AMHPs, senior managers and other stakeholders through semi-structured interviews. In addition, we analysed the Approvals Register in England, which has helped identify overall numbers and patterns of availability of s12 doctors for undertaking MHA assessments on a fee-paying basis. This is of value to understand some of the scale of the problem and has also complemented some of the themes emerging from analysis of the interviews.

In this Chapter, some of the implications of the findings will be explored and links made to other research and evidence, before suggesting some policy options for improving availability of s12 doctors. Some of the insights from the research may also have implications for training and the model of s12 working, for example through gaining a better understanding of the role of fees and independence. Figure 10.1 presents a schematic view of the complex factors that we have identified as contributing to the availability of s12 doctors for MHA assessments and other factors affecting delays of MHA assessments. In this chapter, we shall explore each area of the study separately, referring to Figure 10.1 for illustration.

10.1. Analysis of the Approvals Register
The analysis was exploratory, and some caution is needed, particularly in relation to rurality and deprivation: the findings in relation to these topics must be seen as indicative because of the amount of missing data and possible different completion patterns.

It is hard to interpret overall numbers and the numbers available for fee-paying MHA assessments in terms of adequacy, given the lack of good data on MHA assessments. There were 50,893 new detentions under the MHA 1983 in 2019-2020, which is likely to be an underestimate because not all providers submitted data to NHS Digital, and some submitted incomplete data (NHS Digital, 2020). Also, there are no data on numbers of MHA assessments where the person was not detained under the MHA 1983, nor about the s12 doctors who attended (e.g., the numbers of consultants or Speciality Trainee psychiatrists), or the number of attempts before their attendance was secured. Interpreting these numbers needs to be seen in the context of a large increase in the number of detentions (and therefore MHA assessments), with only modest increases in the numbers of psychiatrists (NHS Digital, 2019), as we noted in Chapter 1.

The figures about the availability of s12 doctors with different sub-specialisms support the interview findings about the difficulty of securing the involvement of s12 doctors who specialise in CAMHS-related work or intellectual disabilities, although it is not possible to indicate the actual adequacy of numbers with these sub-specialisms. The vast majority of s12 doctors making themselves available for MHA assessments on a fee-paying basis were senior psychiatrists (consultants or Speciality Trainee psychiatrists, with at least 3 years’ specialist training). However, we do not know the proportions of assessments completed by different grades of doctors, although given the proportions, it suggests that most assessments would involve at least one senior psychiatrist, which is to be welcomed, given the importance of the decisions being made at MHA assessments. Further data on MHA assessments would make it possible to make more definite statements about this.
Many interview participants reported that ensuring the involvement of s12 doctors in MHA assessments was more difficult in rural areas (as presented in Figure 10.1), and different reasons were identified. The Approvals Register analysis suggests that there are lower numbers of s12 doctors available for MHA assessments in rural areas, further supporting the reported difficulties. Weich et al. (2017) found that people living in more deprived areas were more likely to be detained under the MHA 1983 compared to people living in less deprived areas. Interestingly, the analysis suggested that if anything there were more s12 doctors (whether available or not) in less deprived areas, suggesting that the lack of availability of s12 doctors is unlikely to have been a factor in this difference.

Overall, however, the analysis raises more questions than it answers. Most clearly it points to the need for more data on MHA assessments in relation to overall numbers and the professionals involved in undertaking them, time taken and so on. Also, the analysis suggested the need for further data on whether the s12 doctors undertaking MHA assessments are working independently and their location. Introducing the ability for s12 doctors to update their availability on the Approvals Register would also be of value. Given that changes to the MHA 1983 are envisaged, there appears to be a good opportunity to work closely with AMHPs, s12 doctors and the providers of the S12 Solutions app to develop a dataset and a focused approach to collecting data about MHA assessments. Good data on MHA assessments would be useful for practice and for monitoring and evaluating practice, especially if it could be collected as baseline information to inform the implementation and evaluation of a proposed new MHA. It would also be very useful and seemingly highly relevant to workforce and other equalities to collect data on ethnicity and gender in an expanded Approvals Register of s12 approved doctors and Approved Clinicians.

10.2. Motivating factors
Becoming s12 approved was seen by participants as an essential and routine part of the training path for psychiatrists and the role of psychiatrists. This suggests that little extra motivation to become s12 approved is required for these doctors to become s12 approved. However, only about a third of s12 approved doctors indicate on the Approvals Register that they are willing to be contacted about undertaking MHA assessments on a fee-paying basis. This was in line with the views of AMHPs, in this study. When they were asked about the reasons for delays to MHA assessment, they stressed that availability rather than overall numbers of s12 doctors was the more important element causing problems.

Motivations for hospital psychiatrists to make themselves available to undertake MHA assessments on a fee-paying basis and for GPs, other doctors and those who have retired to undertake this work are more complex. This is an optional part of hospital-based doctors’ work, not required by their contract (although it was in one Trust) and this work is undertaken for a fee on top of their salaries. Completely independent s12 doctors appeared to see undertaking MHAs as being a flexible and contained task, which chimes with evidence about why social workers become AMHPs (Gregor, 2010; Morriss, 2016; Watson, 2016). Working as a completely independent s12 doctor also was valued as a way for retired doctors to maintain a link with practice and earn some extra income.

These findings support the need for increased efforts to motivate and reward hospital doctors to undertake MHA assessments outside their NHS contracts and to encourage GPs and retired doctors to become s12 approved, make themselves available, and to do this work independently, as shown in Figure 10.1.

10.3. Organisational contexts
Organisational relationships and responsibilities varied across different areas. Responsibility for funding the fees paid to s12 doctors lies with the CCG (s236 NHS Act 2006). However, some CCGs...
pass a budget over to NHS Trusts to manage this process and some pay s12 doctors directly. This was identified by s12 doctors as contributing to the complexity about claiming fees. Where the budget is held by the CCG, this creates a disconnect between the Trust, and the CCG, which is financially responsible. This is problematic, because the Trust has the power to make most arrangements for s12 doctor availability (for example, via a dedicated Trust-doctor rota). However, if the Trust holds the budget for paying fees for s12 doctors, there is a strong incentive to limit the numbers of independent s12 doctors undertaking assessments. This could affect availability (as shown in in Figure 10.1), given the reported problems accessing Trust s12 doctors. Whichever arrangement is best, decisions about whether Trusts should be given a budget or CCGs pay fees directly could be made without changes to the MHA 1983 and would be clearer for AMHPs and s12 doctors and may help develop an approach to improving local availability. Piloting and monitoring different approaches could help establish local best practice particularly as CCGs get replaced by Integrated Care Systems.

Governance of independent doctors appeared to be primarily a matter of AMHPs’ choice to use or not use particular s12 doctors, which represents a de facto form of governance, but one which is not transparent and therefore defendable or challengeable. There does not seem to be any Trust oversight of the quality of MHA assessments or complaints procedures, for example. Some mentioned the role of Mental Health Act Officers giving feedback to all independent s12 doctors on the legality of their recommendations but the nature and scope of this are unknown. While there is some Trust-based review of the quality of this information, these measures do not add up to direct Governance.

There were also some calls for more direct monitoring and feedback of the quality of MHA assessment recommendations by all s12 doctors. While this only has tangential importance for improving access to s12 doctors, increasing these requirements could give AMHPs more confidence that the performance of s12 doctors in relation to MHA assessments was being assessed in some way. It would also help raise the profile of this work.

As we noted in the literature review (Stevens et al., 2020), there was little evidence about where s12 doctors fitted into organisations, whether there should be dedicated s12 doctors, or what is the best balance between community-based and hospital-based teams. This was not raised in the current study, although many of the questions raised by this study, about governance, the definition of independence and the role of independent s12 doctors will bear on debates about the best organisational placement of s12 doctors. Again, further data collection and research would be needed to investigate the impact of different factors.

10.4. Training
The matter of training standards and assessments is not central to the main focus of this research, but there is clearly some controversy about the need for further development and particularly assessment. Concerns about the quality of s12 approved doctors will be likely to affect the quality and time taken for MHA assessments, which may influence difficulties in accessing s12 doctors to undertake them.

The literature review conducted as the base of this study (Stevens et al., 2020) identified a gap in evidence about the effectiveness of s12 approval training. Training for s12 approval is usually a two-day course (Rigby and McAlpine, 2019), which is currently (Summer 2021) being run mainly online (Royal College of Psychiatrists (RCP), 2021b). For psychiatrists being trained and practising in hospitals, undertaking s12 work was felt by participants in the current study to build on existing knowledge and experience and therefore they felt the current training was sufficient. Independent verification of this is not available.
However, some NHS psychiatrists contested whether they have had sufficient training about their specific role under the MHA 1983. Several studies have found evidence about psychiatrists’ lack of knowledge of the MHA 1983. Rigby and McAlpine (2019) refer to earlier evidence, questioning s12 doctors’ ability to give the definition of mental disorder. Wadoo et al. (2011) found that junior psychiatrists’ knowledge of the MHA 1983 was ‘patchy’ (p. 460), but that it increased with more training and particularly for doctors who had taken at least part of the MRCPsych exam, required for psychiatrists to become full members of the RCP (2021a). Finally, Mason et al. (2012) identified some concerns about the quality of medical reports of MHA assessments, particularly in relation to making connections between psychiatric symptoms and the legal criteria for compulsory admission to hospital. All these papers argued for increasing training in the use of the MHA 1983 and the need for formal post-course assessment, for all psychiatrists and particularly for s12 approval training. They also support the need for more governance of MHA assessment work by Trusts.

Rigby and McAlpine (2019) analysed the learning objectives for s12 approval training and argued that formal assessment of skills and some more practical assessment, such as a case discussion, is required, in line with assessment of other competence training. This reflects Mason et al.’s (2012) findings that s12 doctors were concerned about training in some of the more practical aspects of MHA assessments, such as completing the paperwork. Again, the findings of our study suggest that a focus on these elements would be welcomed by s12 doctors.

Two rebuttal letters relating to Rigby and McAlpine (2019) were published in the British Journal of Psychiatry Bulletin: Gupta and Calthorpe (2020) and Khwaja (2020, submitted on behalf of the four CAPs). Khwaja made a strong defence of the current approval arrangements: of particular relevance here is the argument that potential s12 doctors will not be learning about MHA assessments for the first time and that there are other requirements before s12 approval is granted. This reflected the views of many of the hospital s12 doctors, KIs and the CAPs interviewed in this study. Rigby and McAlpine (2020), in their ‘Authors’ response’ to the letters argued that, while there was little evidence about the level of s12 approved doctors’ skills, introducing assessment would be a good way of showing that approval courses were providing doctors with this knowledge. Given the practical nature of the assessment process Rigby and McAlpine (2020) argued for a requirement that all s12 approved doctors undertake an observed assessment, which chimes with some of the calls for more case-based discussion in training from participants in this study.

A small number of participants whom we interviewed questioned the role of referees in approval and re-approval processes: echoing concerns raised by Rigby and McAlpine (2019), for whom the absence of a framework for referees made it hard for them to judge whether a doctor was suitable for becoming s12 approved.

Some GPs and some KIs in our study identified a need for different and extra training for GPs and other non-psychiatrists to become s12 approved, in addition to the current extra requirement for observed assessments. These doctors have much less experience of psychiatry and the MHA 1983. Participants argued that such extra training might attract GPs to undertake the training and become s12 approved and increase the numbers available, although one also pointed to the potential for an increased requirement to be off-putting. However, there is little evidence or debate about the need for a different approach to s12 approval for non-psychiatrists: this may suggest an area for further research.

Joint training for AMHPs and s12 doctors was universally thought to be potentially valuable for developing mutual understanding and to promote good working relationships. However, no participant raised it as an idea after being asked a fairly general question about what might improve
accessibility of s12 doctors. This may mean it is not a very salient matter for participants: as Jimenez and Oruzco (2021) argued, initial answers to generic questions (or ‘prompts’) tend to elicit the most important elements for participants. Nevertheless, there is evidence of the benefits of interprofessional education as a way to improve practice (Guraya and Barr, 2018), and an exploration of the role of joint training seems sensible.

10.5. Working as a s12 doctor

Independent s12 doctors must make their own arrangements for support, such as peer groups. Some found this challenging, but many accepted this as inevitable for work outside of the NHS. It may be thought more difficult for some s12 doctors, such as GPs or retired doctors, to do this given their lack of ongoing psychiatric supervision, compared with NHS psychiatrists undertaking some MHA assessments on top of their usual work. How and whether to support completely independent s12 doctors and hospital-based s12 doctors working outside their NHS contracts may influence their willingness to start and to continue the work, as well as potentially contribute to the quality of assessments.

The level of fee, the rules about when s12 doctors are eligible for it and payment arrangements were all identified as potentially limiting the willingness of independent s12 doctors to undertake MHA assessments, as illustrated in Figure 10.1. The literature review identified anecdotal evidence that increasing fees may improve the availability of s12 doctors (Anonymous NHS manager, 2016; North Cumbria Clinical Commissioning Group, 2019). Certainly, many participants in the current study would support the view that increasing the fee may help availability of s12 doctors. Simplifying the process of claiming fees (which was one of the most valued features of the S12 Solutions app: see below) may also increase availability of s12 doctors.

The suggestion from a small number of participants, to include undertaking MHA assessments as a part of an NHS s12 doctor’s core duties would mean an end to paying fees for MHA assessments for these doctors.

Requiring all s12 doctors to do MHA assessments as part of their work for their Trusts could simplify the situation in relation to finding 12 doctors but would raise a question about who pays for this, given that CCGs currently have responsibility for managing the budget for independent s12 doctors’ fees, although sometimes they pass on this responsibility to the local Trust. This point was also supported by a member of the consultation group when we presented initial findings. Furthermore, such a change is likely to increase workforce demands, in the context of a shortage of psychiatrists (RCP, 2019), a point also made by a member of the consultation group. However, such a move could make it easier to manage and govern the service as well as ensure s12 doctors are supported. Different options would need to be explored to work out how best to balance availability for MHA assessments with other clinical duties.

10.6. Arranging MHA assessments

As we present in Figure 10.1, information about availability of s12 doctors to undertake MHA assessments, particularly on a fee-paying basis was of great importance in supporting AMHPs to access s12 doctors. Local lists, the regional Approvals Registers and the S12 Solutions app were all used to some extent, although local lists and the S12 Solutions app were identified as most useful. Increasing consistency in relation to information about availability seems likely to be valuable in improving availability.

The variation in AMHPs’ views about the importance of including s12 doctors with particular sub-specialisms, suggests different interpretations of the MHA 1983 and the Code of Practice (DH, 2015: para 14.39) about what counts as a needed sub-specialism and the best ‘team’ for the patient. What
may be considered the ‘best’ team for an MHA assessment will be different for each assessment. Further research would be needed to explore what kinds, if any, of sub-specialism are needed in different circumstances and why. This may help develop guidance for AMHPs about when and why it is important to ensure that one of the s12 doctors has relevant specialist knowledge.

Most participants in this study felt that having a doctor who knows a patient is better for the quality of assessment and was a less difficult experience. Blakely et al. (2021) interviewed people who had experienced being assessed under the MHA 1983: they valued relationships and ‘someone to sit and listen’ (Blakely et al., 2021: 3). This would suggest the value of having a s12 doctor with prior acquaintance. In addition, Roche et al. (2014) found that patients’ perceptions of the procedural justice of the MHA assessment ameliorated the negative impact of compulsory admission to hospital on therapeutic relationships with psychiatrists. Having a known and trusted doctor undertaking the MHA assessments may lead to a greater perception of procedural justice, although this might be equally well accomplished by an Independent Mental Health Advocate (IMHA). However, one participant in our consultation who had been assessed by a doctor who had been treating them described how this had negatively affected their later relationship with the doctor. Further research would be needed to understand more fully the impact of having a known doctor undertake the MHA assessment. Such evidence would help inform decisions about whether there should be increased emphasis on the requirement to have a doctor with prior acquaintance ‘where practicable’ (DH, 2015: para 14.73).

The Mental Health (Conflicts of Interest) (England) Regulations 2008 do not prohibit two doctors from the same Trust undertaking an MHA assessment. However, the Code of Practice (DH, 2015: para 39.4) states that it is good practice for the two doctors not to be employed by the same Trust. This tension was reflected in the participants’ views. The size of the Trust and former relationships with consultants and other s12 doctors were identified as factors influencing decisions about whether this would be acceptable. The position taken about independence also affected the balance of using s12 doctors doing assessments in their NHS contracted time and independent s12 doctors and could be another influence on availability, as shown in Figure 10.1. A decision on the value of the level of independence or at least clarity over how decisions about the independence of two s12 doctors could be made, might make it easier for AMHPs to access s12 doctors. Members of the consultation group felt that the independence of s12 doctors was an important safeguard. Consequently, independence may be valued over the ease of arrangements: in some areas, implementing the requirements of independence in relation to doctors working for the same Trust could cause delays in MHA assessments. Further research exploring the outcomes and perceptions of the quality of MHA assessments involving s12 doctors with different levels of independence may help inform decisions about this.

10.7. Relationships between doctors and AMHPs
Overall, working relationships between AMHPs and s12 doctors, in respect of MHA assessments were reported to be positive. Some tensions were described, relating to pay and different models of practice and the responsibility for securing beds. This was problematic: AMHPs reported that the s12 doctor would very often leave soon after the assessment was concluded and a decision made, a picture found in other research (Stevens et al., 2018; Stone, 2016; Vicary, 2016). Also, in accord with a previous study (CQC, 2018), the impact of the breakdown of s75 agreements was felt to have made managerial and organisational relationships more difficult, which hindered good professional relationships and made it more difficult for AMHPs to secure s12 doctors’ involvement in MHA assessments. Co-location and regular communication between s12 doctors and AMHPs were identified as being important to developing and maintaining good working relationships, over and above the value of integration.
10.8. Technological resources

Two main technological resources were identified, before the interviews: the Approvals Register and the S12 Solutions app. The interview findings, in combination with the analysis of the Approvals Register, suggest that the functions of the Approvals Register would appear to be worth reconsidering and to question whether it is fit for purpose. In the main, it seemed to be used, occasionally, to check that someone is on the Approvals Register, rather than as a tool to aid securing access to s12 doctors: this would seem to be a very limited justification for running this kind of Register. Overall, the Approvals Register appears to command little interest, but its potential might be further explored. This would necessitate better completion of the Approvals Register to help with workforce planning.

Broad support was expressed for the S12 Solutions app, which was felt to support initial access, fee payment and faster transfer of information about outcomes of MHA assessments as well as potentially informing workload management. This supports the findings of the independent evaluation of the app (Gale, 2020). However, there were some questions about the impact on practice. For example, whether ease of access to a wide range of s12 doctors might mean AMHPs are less likely to seek the involvement of a s12 doctor who knows the patient. This would require further research to explore. A small number would have preferred the app to be developed and owned by the DHSC, not a commercial company (in April 2021 Section 12 Solutions Ltd was acquired for the sum of £3.98 million in cash and shares by Vitalhub Corporation, based in Canada). If the role and functions of the Approvals Register are reconsidered, there may be some scope for integrating them with the app subject to data protection, governance, and cost considerations.

In accord with these findings, members of the consultation group supported the idea of technological solutions to improving availability of s12 doctors. For example, one suggested developing an Uber-style approach, which is not far from the functionality offered by the S12 Solutions app.

10.9. Use of rotas

Creating and maintaining rotas of s12 doctors was a typical approach to ensuring their availability, hence their inclusion in Figure 10.1. These were almost all rotas for s12 doctors undertaking MHA assessments in NHS paid time, rather than for independent s12 doctors. In some areas s12 doctors are expected to undertake s12 assessments as part of their general on-call shifts. There was no indication about which works best, and we found no other research evidence about this. This is because of the variety of arrangements, the lack of information about and possibly a lack of interest in MHA assessments.

Where a rota existed and was staffed, it was felt to be helpful in accessing s12 doctors. How to staff a s12 rota, while not making it more difficult to staff other clinical duties, is another question raised by participants and this would require detailed work to inform decisions about the best approach. Rota development is a complex field, requiring detailed development work and evaluation (Cass et al., 2003). Turner et al. (2015) explored factors required to link capacity and demand in a hospital emergency setting. They concluded that data on demand, as it varies across time is crucial to be able to staff a service properly. Again, this supports the need for more data on MHA assessments to support the development of s12 rotas, given their potential to facilitate MHA assessments. The research has identified factors that would need to be considered in managing rotas: unpredictability of demand; numbers of consultants and other s12 doctors and geographic factors. Without a functioning rota for s12 doctors, it is difficult to see how a Trust can contribute to supporting greater availability of s12 doctors.
10.10. Obliging the NHS to ensure sufficient s12 doctors are available for MHA assessments

There was clear support for requiring NHS CCGs (in the emerging context this would be Integrated Care Systems) or Trusts to ensure sufficient numbers of s12 doctors were available. To implement such a requirement, clarity is needed over whether CCGs or Trusts would be responsible, and how this would operate in relation to the availability of independent s12 doctors, who operate outside the NHS. There appears to be variability between Trusts over whether undertaking MHA assessments is required by psychiatrists’ contracts. For CCGs or Trusts to meet any such requirement would necessitate some national steer on the place of undertaking MHA assessments in psychiatrists’ contracts. Also, there is no current way of knowing what number of s12 doctors would be sufficient; a similar problem tends to undermine the importance of the requirement on local authorities to ensure a ‘sufficient’ number of AMHPs are available (DH, 2015, para 14.35).

10.11. Waiting time standard

There was broad opposition to the idea of introducing a waiting time standard, which The Independent Review of the Mental Health Act 1983 (DHSC, 2018) recommended that the Government should consider, although some felt such a standard would help establish more parity of esteem between physical and mental health. The Review emphasised that the implementation of such a standard would have to be ‘appropriate and safe’ (DHSC, 2018: 217) and most of the professionals we interviewed doubted it would be feasible to establish what time standards were ‘appropriate and safe’. As we have seen, MHA assessments are extremely variable, in terms of clinical concerns, social factors and local contexts, which many thought make it difficult to identify an appropriate waiting time. Others felt that waiting time standards in general created incentives to avoid breaching the limits, which could lead to negative practices or the neglect of other areas. Waiting time standards for assessment by a specialist mental health professional for urgent referrals are being trialled: it is not clear whether this includes MHA assessments (The NHS National Medical Director, 2019). Overall, this research does not support the development of a waiting time standard for MHA assessments.

10.12. Conclusion

Our analysis of the Approvals Register was the first to be undertaken in any detail. It generally supports our interview findings, where many AMHPs had experienced increased difficulty in accessing s12 doctors in rural areas and at night and in securing the involvement of s12 doctors with specific sub-specialisms in most areas. Interview participants also stressed the importance of organisational complexity, shortages of mental health beds (which affects delays in implementing decisions made at MHA assessments). Figure 10.1 presents the suggested impact of these factors in schematic format, based on the factors identified by participants in this study. They are further illustrated in relation to two extreme situations: MHA assessments needed at night in a rural area (Figure 10.2), which are likely to take longer to arrange than MHA assessments initiated in a city hospital, during the day (Figure 10.3). Other factors such as the need to negotiate with Nearest Relatives are
Figure 10.1 Factors affecting MHA assessments delays

1. S12 Solutions app, Register, local and individual lists
2. Nearest Relative can also request a MHA assessment
3. s136 place of safety, hospital, community, Police station
4. E.g. intoxication
5. E.g in relation to independence of the s12 doctors undertaking a MHA assessment
Figure 10.2: Influences on time to implementation 1: Urgent late night community referrals in a rural area

Arrange
Availability of AMHPs
Availability of doctors
Access to information*
Local Trust policies
Police availability
Securing warrants
Travel time

Assess
Access to medical notes (independent s12 doctors)
Patient factors

Implement
Bed availability
Ambulance response

*e.g. S12 Solutions app
Figure 10.3: Influences on time to implementation 2: Consultant daytime referral in a city hospital

Arrange
- Availability of AMHPs
- Availability of doctors (but only one additional doctor required)
- Access to information*

Assess
- Patient factors

Implement

*e.g. S12 Solutions app*
not included as they were not raised by participants. This suggests policy options at national, organisational and individual levels.

A national review of organisational responsibilities and financial arrangements may be of value in helping to establish clearer roles and responsibilities, including financial control. While slightly out of the scope of this research, addressing the shortage of mental health beds would also reduce the delay between referral and implementation of decisions (Perkins and Repper, 2017; Stevens et al., 2018). ‘Beds’ of course may not be the most helpful option, good sufficient community-based care or home treatment might also be of help. Also, at national level, policy on s12 approval training and other requirements could also influence numbers, particularly of independent s12 doctors, as could decisions about their role in the process. It may also be useful to consider potential implications of requiring MHA assessments in doctors’ contracts.

Organisationally, relationships between CCGs and NHS Trusts, especially decisions about budgets can affect availability as can local policies about the priority of selecting NHS rather than independent s12 doctors to undertake MHA assessments. The level of integration or relationships between Trusts and local authorities were also felt potentially to influence the ease of accessing s12 doctors. Mounting promotion campaigns and cascading encouragement by supervisors and other managers are interim measures that may increase availability.

At a more micro level, developing opportunities for joint training of AMHPs and s12 doctors and other opportunities for contact outside MHA assessments was felt potentially to improve working relationships. While this is tangential to increasing availability, by encouraging good relationships, this may help improve accessibility.

However, there are two main findings from the research. First is that the main problem is availability of s12 doctors, rather than overall numbers. At the moment only half of s12 doctors are available out of hours and about a third will do MHA assessments on a fee-paying basis. This is important, as often, the most difficult aspect is to arrange for the second opinion doctor, who is usually operating independently. Including undertaking MHA assessments as a requirement in NHS contracts may also be of value, although careful consideration of the impact on workload would be needed.

Second, more routine data collection on various aspects of MHA assessments is required for workforce planning that could identify how many s12 doctors are needed or to develop better approaches to improving availability of s12 doctors. Data would be needed on overall numbers of assessments, the basis on which s12 doctors were working, the involvement of s12 doctors with different sub-specialisms and delays. Identifying the necessary datasets and planning data collection would help establish whether the existing Approvals Registers are used to their full potential or need changing. Finally, if the role of the Approved Clinician is to grow then there is scope to know more about this part of the mental health workforce and the exercise of its powers.
References


King’s College London (2021). Applying for Ethical Clearance. 


The Mental Health (Conflicts of Interest) (England) Regulations 2008, reg . 6(1)(a).


**Data references**


